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PARENT-CHILD CO-SLEEPING IN YOUNG TURKISH CHILDREN

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Parent – Child Co-Sleeping in Young Turkish Children

Türkiyeli Ebeveyn ve Çocuklarda Birlikte Uyuma

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ABSTRACT

This study aims to examine parent-child co-sleeping in young Turkish children. In this study, the relationships between the children's sleeping arrangements with the maternal attitudes towards sleeping arrangements, the mother's attachment security, the mother's anxiety level, and the child's temperament characteristics were investigated. Moreover, the 18-48 months old children's sleep practices and their mothers' perception of sleep problems in the different sleeping arrangements were examined. An online survey link was reached to the parents via social media and the kindergarten communities. Participants who volunteered to participate in the study filled the Demographic Form, The Sleep Practices Questionnaire, The Parental Sleep Attitude Scale (PSAS), and The Experiences in Close Relationships-Revised (ECR-R), The State-Trait Anxiety Inventory (STAI I-II), the Activity Level, Fear, Frustration, Soothability and Perceptual Sensitivity subscales from The Early Childhood Behavior Questionnaire-Short Form (ECBQ). The responses of 1055 mothers who had 18-48 months old children were analyzed for the study. The co-sleeping rate was found to be 69% in young Turkish children.

Many reactive co-sleeping children were early co-sleepers which indicated a different manifestation of reactive co-sleeping. Mothers of intentional co-sleeping children differed in their attitudes towards sleeping arrangements. They favored bedsharing more than mothers of reactive co-sleeping and mothers of solitary sleeping children. Extended breastfeeding was more common in intentional co-sleeping children's mothers.

Mothers of reactive co-sleeping children had higher anxiety levels, higher attachment anxiety, higher attachment avoidance than mothers of intentional co-sleeping children and mothers of solitary sleeping children. They also reported more difficult temperament, and they perceived more sleep problems than the mothers of intentional co-sleeping children and the mothers of solitary sleeping children. Co-sleeping children's mothers reported that they received criticism more frequently than solitary sleeping children's mothers. The findings were discussed in terms of cultural and individual factors.

Keywords: children, sleep, co-sleeping, sleeping arrangements, adult attachment

ÖZET

Bu çalışmanın amacı, yaşı 18-48 ay arasında değişen çocukların ebeveynleri ile birlikte ya da ayrı uyumalarının, annelerin birlikte ve ayrı uyuma hakkındaki tutumları, annelerin bağlanma kaygı ve kaçınması, annelerin kaygı düzeyi ve çocukların mizaç özellikleri ile ilişkisini incelemektir. Ayrıca, çocukların uykuya geçiş alışkanlıklarını ve annelerinin çocuklardaki uyku problemi algısını incelenmiştir. Katılımcılara sosyal medya ve anaokulları aracılığıyla çevirmiçi anket ulaşıltırılmıştır. Katılımcılar demografik formu, Uyku Alışkanlıkları Anketi'ni, Ebeveyn Uyku Tutum Ölçeği'ni, Yakın İlişkilerde Yaşantılar Envanteri'ni (YİYE-2), Durumluk–Sürekli Kaygı Envanteri'ni (DSKÖ I - II) ve Erken Çocukluk Dönemi Davranış Anketi Kısa Formu'ndan Aktivite Düzeyi, Korku, Kızgınlık/Hayal Kırıklığı, Azalan Tepki/Sakinleşme ve Algısal Hassasiyet alt ölçeklerini yanıtlamışlardır. 18-48 ay yaş aralığında çocukları için anketi dolduran 1055 annenin yanıtları çalışmada değerlendirilmiştir. Çocuklarda birlikte uyuma oranının %69 olduğu görülmüştür.

Birlikte uyuma, ebeveynlerin tercih ettiği, istemli birlikte uyuma ve ebeveyn tarafından tercih edilmeyen, tepkisel birlikte uyuma olarak iki grupta incelenmiştir. Birçok tepkisel birlikte uyuyan çocuğun, önceki bazı araştırmalardan farklı olarak ilk yıldan beri birlikte uyuduğu görülmüştür. İstemli olarak birlikte uyuyan annelerin birlikte uyumaya dair olumlu tutumları diğer annelere göre yüksek, ayrı uyumaya dair olumlu tutumları ise diğer annelere göre daha düşük olarak bulunmuştur. İstemli birlikte uyuyan çocukların annelerinde uzun süreli emzirme tepkisel birlikte uyuyan çocukların ve ayrı uyuyan çocukların annelerine göre daha yüksek sıklıkla rapor edilmiştir.

Tepkisel birlikte uyuyan çocukların annelerinin kaygı düzeyi, bağlanma kaygı ve kaçınma puanları istemli birlikte uyuyan ve ayrı uyuyan çocukların annelerine göre yüksek olarak bulunmuştur. Tepkisel birlikte uyuyan çocukların korku, kızgınlık/hayal kırıklığı, aktivite düzeyi puanları istemli birlikte uyuyan ve ayrı uyuyan çocuklara göre yüksek olarak bulunmuştur. Tepkisel birlikte uyuyan ocukların azalan tepki/sakinleşme puanları tepkisel birlikte uyuyan ve ayrı uyuyan çocuklara göre düşük olarak bulunmuştur. Tepkisel birlikte uyuyan çocukların

annelerde uyku problem algılama sıklığı daha yüksektir. Bu bulgular, birlikte uyumanın istemli ve tepkisel olarak ayrılarak incelenmesinin önemini göstermekte, çocukların birlikte ve ayrı uyumaları ile ilişkili psikolojik etmenler hakkında bilgi vermektedir. Bulgular bireysel psikolojik etmenler ve kültür bağlamında tartışılmıştır.

Anahtar kelimeler: çocuklar, uyku, birlikte uyuma, uyku düzenlemeleri, yetişkin bağlanması

CHAPTER 1

INTRODUCTION

The child's sleeping arrangement refers to the classification of where and with whom the child sleeps. However, co-sleeping is a sleeping arrangement that refers to the child and the parents sharing the same bed or sleep in the same room. (Goldberg & Keller, 2007). Solitary sleeping is another sleeping arrangement that describes that the child sleeps in a separate room. The definitions of solitary sleeping arrangement type have not been standardized in the studies. The child may sleep alone, or she/he may sleep with her/his siblings in a solitary sleeping arrangement (Goldberg & Keller, 2007; Ramos et al., 2007).

The children's sleeping arrangements have been discussed as a medical, cultural, and psychological issue in the literature (Keller, 2008 & Ramos & Youngclarke, 2006). The scientific literature on the children's sleeping arrangements had mixed evidence of developmental outcomes and predictors of co-sleeping (Mileva-Seitz, 2017). Some explained these mixed findings because of the effect of the culture and the different parental cognitions on co-sleeping (Germo et al., 2007; Lozoff et al., 1996; Luijik et al., 2013; Narvaez et al., 2013).

The culture and the socio-economic level are the main determining factors in the children's sleeping arrangements (Jenni & O'Connor, 2005; Keller, 2008; Morelli et al., 1992; Shimuzi et al., 2014). Co-sleeping is the norm for non-industrial societies and many Eastern societies (Morelli et al., 1992; Shimuzi et al., 2014). In Western societies, the typical sleeping arrangement is solitary sleeping (Sadeh et al., 2010). In these societies, co-sleeping has been usually seen as a response to the child's sleep problems (Lozoff et al., 1985), but some families still prefer co-sleeping (Keller & Goldberg, 2004). Researchers have divided co-sleeping into reactive co-sleeping and intentional co-sleeping. Reactive co-sleeping indicates that the parents practice co-sleeping, although they do not prefer co-sleeping. In intentional co-sleeping, the parents prefer co-sleeping, and they have positive attitudes towards co-sleeping (Madansky & Edelbrock, 1990; Keller & Goldberg, 2004; Ramos, 2001).

Sadeh and Anders (1993) introduced a transactional model of infant sleep. The transactional model of infant sleep has demonstrated the interactions and the bidirectional relationships contributing the infant sleep. Various proximal factors are contributing to infant sleeping patterns. Some of them are listed as follows: the personality of parents, psychopathology, parental cognitions and the infant factors like temperament, general health, and age; and the parent-infant relationship (i.e., attachment, care, daily interactions, bedtime interactions, soothing methods, limit setting). The culture, including the norms and the media, the environment (i.e., socio-economic factors, physical conditions, geographical conditions), and the family-related factor (i.e., family stress, spouse relationships, siblings) are the distal factors that were related to the infant's or child's sleep (Sadeh & Anders, 1993; Sadeh et al., 2010).

Considering the transactional model of sleep, the family, the parental factors, the child factors, and the interaction between these factors are essential to understand the differences in the sleeping arrangements within a society. In the present study, maternal attachment, maternal attitudes, maternal anxiety, and the child's temperament will be investigated in relation to the sleeping arrangements.
The child's age is an important factor affecting the sleeping arrangements of the children. The sleep characteristics of young children change as the child grows up. The prevalence of co-sleeping decreases in school-age children in many societies (Caudill & Plath, 1966; Cortesi et al., 2008; Kahraman & Ceylan, 2018; Okami et al., 2002). This study aims to investigate the sleeping arrangements of 18-48 months old Turkish children with a non-clinical sample. Demographic factors, some child factors (temperament), some maternal factors (attachment, anxiety, attitudes, perceptions of sleep problems), sleep onset behaviours, and parental night-time behaviours will be investigated in this study in relation to the children's sleeping arrangements. Furthermore, the study aims to describe the characteristics and the differences between intentional co-sleeping, reactive co-sleeping, and solitary sleeping of Turkish children.

The literature review will begin with the historical background of the children's sleeping arrangements. The debate on co-sleeping will be summarized

from different viewpoints. Then, the research related to the attitudes towards sleeping arrangements will be reviewed. Normal toddler sleep behaviors and sleep problems will be summed up afterward. The literature on the relationship between sleep problems and co-sleeping will be discussed. Lastly, children's sleep arrangements will be discussed in terms of attachment, maternal anxiety, and the child's temperament with the theoretical backgrounds and the research findings.

1.1. LITERATURE REVIEW

1.1.1. Socio-Cultural Perspectives on Parent-Child Co-Sleeping

Sleep habits have changed throughout history depending on social conditions (Arber et al., 2012). The privacy of the sleep environment is a recent circumstance. In medieval society, bedrooms were not private places. Many people, including guests, could sleep in the same bed (Elias, 1978). Elias (1978) described the transition from public sleep to private sleep as a process of civilization. He explained that civilization includes self-control of the body and the privacy of the animal aspects of the human body. Sleep, as an animal aspect of the human body, has become a private act.

In human history, young children slept with their parents for survival. With the transition to the settled life, cribs were designed. Sleeping on the same surface with their young children has become an option for the parents rather than a necessity after the invention of the cribs (Thoman, 2006). However, solitary sleeping, which means sleeping of the child in a separate room, has been common in Western society after The Industrial Revolution (Stearns et al., 1996). In non-industrialized societies, co-sleeping has still been the norm (Barry & Paxon, 1971; Crittenden et al., 2018; Morelli et al., 1992).

In post-industrial societies, researchers showed that solitary sleeping is the most common type of children's sleeping arrangement among American and European families, but co-sleeping is not rare (Madansky & Edelbrock, 1990; Mindell et al., 2013; Okami et al., 2002; Schahter et al., 1989). Mindell et al. (2013) found that the co-sleeping rate in 0-36 months old children is 32% in Australia, 33% in Canada, 17% in New Zealand, 43% in the US, and 26% in the UK. The age of the child affects the co-sleeping rate. Okami et al. (2002) found that the co-sleeping rate is 35% in infancy, 7% at three years old, and 10% at four years old in middle-class Euro–American children. However, the highest rate has not always been seen in infants. Researchers reported that the co-sleeping rate of Swedish children is 10% for infants and 38% for four years old children (Jenni et al., 2005). The prevalence of co-sleeping has declined dramatically after the child is 6-7 years old in Western societies. For example, the co-sleeping rate in school-age children was found to be

5% among Italian children (Cortesi et al., 2008). Other demographic factors affecting the prevalence of co-sleeping are the ethnicity and the socio-economic status of the family. Low SES families have been found to be more likely to co-slept (Lozoff et al., 1985; Milan et al., 2007; Willinger et al., 2003; Keller, 2008, Ramos, 2001). The co-sleeping rate has been found to be high in low SES families controlled for ethnicity, and it has been found to be high in African American and Asian families when controlled for the socio-economic status (Keller, 2008).

Stearns et al. (1996) explained why solitary sleeping became widespread after the Industrial Revolution: First, the household population has decreased after The Industrial Revolution. Domestic help has become rare; the grandparents have become living in separate houses, the older children have begun to school rather than caring for their little siblings. The parents became the only people who take care of the children. Second, the women have participated in the working life. As a result, the women's need for rest and private time has been increased (Stearns et al., 1996).

Writers also emphasized the effect of the media and the children's experts like pediatricians on parenting styles. In the 20th century, experts' ideas began influencing child-rearing practices. Following the socio-cultural context of the Western countries, the independence and the autonomy of the children have been emphasized by the experts. In the U.S. and Europe, most psychologists and pediatricians suggested that solitary sleeping is the healthiest sleeping arrangement for children (Lozoff et al., 1985).

Although the Industrial Revolution has influenced the children's sleeping arrangements in Western societies, industrialized Eastern societies have continued practicing co-sleeping (Shimuzi et al., 2014). For example, in Japan, the co-sleeping rate was reported as 90% for infants, 91% for 1-5 years old children, and 79% for 6-10 years old children (Caudill & Plath, 1966). The same tendency has continued into the 21st century. The co-sleeping rate was reported as 89% for five years old children in Japan (Iwata et al., 2013). Mindell et al. (2013) found that 83% of preschool-age children co-sleep in South Korea.

Researchers explained the significant differences in the co-sleeping rates across industrialized cultures by Hofstede's (1980) Cultural Dimensions Theory (Caudill & Plath, 1966; Jenni & O'Connor, 2005). Hofstede (1980) suggested the dimension of individualism/collectivism to distinguish cultures. Individualism emphasizes the individual ("I"). In contrast, collectivism emphasizes the group ("we"). Firstly, it is important to note that individualism and collectivism are not opposite ends. Still, they are permeable dimensions, especially when the matter is child socialization or parenting behaviour (Keller, 2003). Besides, research evidence has demonstrated that children's sleeping arrangements have within-culture differences as the co-sleeping rates indicated.

The parental goals in collectivist cultures are relatedness to the family, harmony, nurturant relationships, inhibited hedonism, respect and obedience, responsibility to others, and achievement of the community's goals (Greenfield et al., 2003; Triandis, 1995). The collectivist cultures prioritize the family and the community rather than the individual. The nutrient relationships and harmony between family members are valued (Javo, 2010). On the other hand, the parental goals in individualistic cultures are independence, autonomy, self-maximization, and expressiveness. In individualistic societies, the parents encourage and praise independent behaviour. Individualistic cultures distinguish individuals from society and the family (Javo, 2010; Triandis, 1995). Caudill and Weinstein (1969, pg.15) explained how the approach of infant socialization is different in the Japanese and American societies:

> In Japan, the infant is seen as a separate biological organism who from the beginning, in order to develop, needs to be drawn into increasingly interdependent relations with others. In America, the infant is seen more as a dependent biological organism who, in order to develop, needs to be made increasingly independent of others (Caudill & Weinstein, 1969, pg.15).

Keller (2007) described universal parenting systems that consist of primary care, body contact and stimulation, object stimulation, face-to-face contact, and the narrative envelope. All these systems are universal, but culture influences which

system is more intensely used (Keller, 2007). Distal communication such as language use, vocalization, play, face-to-face contact, and object stimulation is more common in individualistic cultures than collectivist cultures (Caudill & Weinstein, 1974; Feldman et al., 2006; Keller, 2007; LeVine, 1990). On the other hand, constant bodily contact, extended breastfeeding, holding - feeding the young child when he/she cried, and co-sleeping has been seen more predominantly in collectivist cultures (Feldman et al., 2006, LeVine, 1990; Rothbaum, Pott, et al., 2000). In agricultural or hunter/gatherer collectivist cultures, the reason is mainly the environmental conditions and raising the survival chance (LeVine, 1990). In industrial collectivist cultures, social harmony and relatedness are valued rather than autonomy (Triandis, 1995). In accordance with this, the mothers fulfill their young children's needs before the children express, creating a "we" entity (Rothbaum, Pott, et al., 2000). They also aim to prevent the expression of distress in the child (Vogel, 1991, as cited in Rothbaum, Weisz, et al., 2000). Researchers and writers emphasized the difference in night-time parenting between individualistic and collectivist cultures. In the U.S., young children and caregivers separate for a more extended period at night, and they meet in the mornings (LeVine, 1990). In the U.S., separations and reunions occur repeatedly. Thus, reunions are important (LeVine, 1990; Rothbaum, Pott, et al., 2000). In some cultures, most mothers and young children are together during the day and at night. For example, many Japanese mothers rarely leave their children to other caregivers. They prioritize closeness to their infants rather than work or couple relationships (Fogel et al., 1992, Rothbaum, Pott, et al., 2000, Rothbaum et al., 2002).

Many Eastern societies like Japan or South Korea or developing countries like Turkey have been transforming from agricultural, communal social structures to an urbanized social system. Individualistic values like autonomy have begun to be adopted in these societies. Due to the social change, both collectivistic and individualistic characteristics have been seen in these developing countries. Researchers indicated that autonomy and relatedness could exist in these cultures (Imamoglu, 1998, 2003; Kagitcibasi, 1996, 2007). Kagitcibası (1996) conceptualized an autonomous-related self. She suggested two separate dimensions

of agency (autonomy-heteronomy) and relatedness (separation-relatedness). She explained that educated individuals in urbanized interdependence-oriented cultures (e.g., Turkey) had an autonomous-related self. Kagitcibasi (2007) suggested an emotional interdependence model which describes the family change in the urbanized interdependence-oriented cultures with material independence and emotional relatedness. She explained that the women had gained a role in work-life, children's psychological value has increased rather than their economic value, nuclear family has become widespread. However, the emotional interdependency between family members and relatives, extended period of nutrient relationships in the family has continued to exist in these cultures.

Similarly, Fisek and Kagitcibasi (1999) used Roland's (1998) "familial self" concept to describe Turkish individuals. The familial self includes closeness and symbiosis, and it can expand with social change and with the different relationships. According to Roland, the individual does not change all cultural beliefs, practices, or attitudes due to social changes; instead, she/he becomes multicultural (Roland, 1988, as cited in Fisek, 2018). He named this structure of the self as "expanding self." The individuals can have contradictory attitudes and tendencies in the expanding self (Fisek, 2018). These conflictual tendencies have also been seen in the co-sleeping literature. For example, Shimizu et al. (2014) explored mothers' co-sleeping experiences in Japan regarding the rising individualistic values. They found that the co-sleeping rate has not been changed, but the mothers reported conflicts with their practices.

In urban Turkey, in accordance with emotional relatedness, the actual parent-child co-sleeping rate is high. However, it is not as high as Japan or South Korea. For infants, the co-sleeping rate has been found as 60-85% (Baskale & Turan, 2017; Boran et al., 2014; Kahraman & Ceylan, 2018, Karacal, 2010, Tasdemir & Temel, 2015). Kahraman and Ceylan (2018) reported the co-sleeping rate as 60-70% for 18-36 months old children. For 36-72 months old preschool children, the co-sleeping rate has been found as 30-51% (Gultekin & Temel, 2020; Karacal, 2010; Ozvurmaz & Calisir, 2018). Co-sleeping is also related to breastfeeding (Ball, 2003; McKenna & Gettler, 2007). The National Ministry of

Health reported the average breastfeeding duration as 15 months for girls and 17 months for boys in Turkey (Turkey Demographic and Health Survey, 2014). According to the World Breastfeeding Trends Initiative, the average breastfeeding duration is 15-17 months in Turkey which is dramatically above European countries, which have the average breastfeeding durations of 4-6 months (Zakarija-Grkovic et al., 2020).

1.1.2. The Debate on Co-Sleeping

Many researchers and writers stated that Western-origin psychology sees separation and independence as fundamental for healthy development. The extended state of interdependency was labeled as psychopathological (Doi & Bester, 1973; Kagitcibasi, 1990; LeVine, 1990; Rothbaum et al., 2002, Sato, 2001). As they noted, many child health care professionals and child development experts stated that co-sleeping was harmful to children's sleep hygiene, an over-stimulation of the child's sexual drives, and not healthy the separation-individuation process (Ferber, 1985; Sperling, 1974; Spock, 1945). They suggested that sleeping alone at night is beneficial for the child who can walk and speak in the separation-individuation processes. They stated that co-sleeping in toddlerhood and beyond prevents the child's independence, and it may cause an extended dependency which is difficult to break (Ferber, 1985; Spock, 1945). For example, Ferber's book (1985), titled "*Solve Your Child's Sleep Problems*", aimed to give a solution to babies' difficulties of initiating and resuming sleep. However, he emphasized the child's individualization process in the book. He proposed that the children learn to cope with the separation anxiety by sleeping alone, and they become more independent and autonomous. Ferber advised bedtime routines and a sleep aid like a blanket or a teddy bear at bedtime. He also suggested not to respond to the baby's crying by touching, rocking, or holding to prevent sleep associations.

Some experts explained the co-sleeping disadvantages with oedipal conflicts (Sperling, 1971; Spock, 1945). Sperling (1971) noted that sharing a bed to solve sleep problems and separation anxiety caused more anxiety in children because of the oedipal conflicts and sexual over-stimulation. Spock (1958) indicated that solitary sleeping is the healthiest sleep arrangement for young

children. Ferber (1985) indicated that the children get anxious because of the sexual stimulation on the parental bed. The research conducted to test these suggestions was quite limited. A longitudinal study with a non-clinical sample conducted in the U.S. measured the cognitive, social, sexual, and emotional status of children who co-slept in infancy and early childhood (Okami et al., 2002). Researchers found no differences between sexual fantasies or preoccupations in projective and objective tests and children's history of sleep arrangements at the age of 6. The results indicated that bedsharing children showed higher cognitive competence on tests than solitary sleeping children.

Another discussed issue about the practice of co-sleeping is family functioning**.** Minuchin (1974**)** described the "enmeshed families" as the families with blurred boundaries between the members, an over-involved mother-child relationship, and a lack of differentiation. The caregivers usually treat their children as if they are younger, and they meet their intimacy needs from their children in enmeshed families. The couple could not resolve conflicts, and the fathers are disengaged in this type of family (Minuchin, 1974). Some noted that co-sleeping might be a sign of relationship problems in the family (Fraiberg, 1959; Humphries, 2015; Kaplan & Poznanski, 1974; Teti et al., 2015; Teti et al., 2016). They suggested that parents sometimes satisfy their emotional needs by children with bedsharing when they are dissatisfied with their spousal relationships. They also proposed that bedsharing prevents the couple's problems from being seen (Humphries, 2015; Kaplan & Poznanski, 1974). Research has supported these arguments. Teti et al. (2015) reported that lower quality of co-parenting in the infant's first days predicted bedsharing while the higher quality of co-parenting predicted solitary sleeping at 6 months. Researchers stated that co-sleeping mothers reported lower marriage quality than solitary sleeping children's mothers (Cortesi et al., 2008; Song, 2010). Co-sleeping has been found to be more prevalent in single-parent families (Brenner et al., 2003; Lahr et al., 2007; Santos et al., 2017). However, some researchers discussed that some parts of the enmeshed family concept are Western-biased. In some regions, the mother-child relationship is prioritized in the family, the fathers are usually disengaged traditionally (e.g.,

Japan, Turkey), and the closeness between mother and the child is culturally valued (Fisek, 2018; Fisek & Kagitcibasi, 1999; Rothbaum et al., 2002). Besides, some researchers noted that when the family bed or co-sleeping is the couple's preference, the situation can change in non-traditional families. Studies showed that the marital role satisfaction was low for co-sleeping families only when the parents practiced co-sleeping due to their children's sleep problems, but it was not low for the parents who co-slept as a choice (Germo et al., 2007; Messmer et al., 2012).

Although it has been a common argument that co-sleeping has adverse effects, after the 1970s, some experts in the U.S. suggested that co-sleeping is a natural practice. They emphasized the importance of night-time parenting for the emotional well-being of the children (Sears, 1985; Thevenin, 1976). Sears (1985) highlighted the physical proximity at night. He opposed the opinion that the child should learn to sleep through the night by himself. He criticized the experts and addressed "the maternal instincts." He asserted that if mothers trust their instincts, they prefer bodily closeness and responsiveness at sleep time. He stated that co-sleeping facilitates breastfeeding and the child's security feeling. He thought that the child's attachment to a non-human object at night indicates the child is forced to a premature separation from her/his human caregiver. He asserted that society pushes children to get independent. He proposed that children get independent when they are ready (Sears, 1985).

Sears and Sears (2002) established the counter-cultural parenting philosophy named "attachment parenting" that emphasizes physical closeness and the empathetic relationship between the mother and the child. Sears and Sears (2002) described attachment parenting as being sensitive to the baby's cues and being accurately responsive to their cues. Sears and Sears (2002) recommended on-demand breastfeeding, child-led weaning, co-sleeping, baby wearing, and responding to the baby's cry. They suggested that attachment parenting reduces the distress of the infants. The philosophy of attachment parenting is not parallel to the attachment theory, but they referenced attachment theory that emphasizes the responsiveness of the caregiver. They also referenced the parenting behaviours in non-industrial cultures. The physical aspects of the parenting style that they

recommended are similar to the traditional parenting style in collectivistic cultures, but they emphasized their autonomy and expressiveness. Attachment parenting has become popular worldwide (Hamilton, 2017; Sieben & Yildirir, 2019). Accordingly, co-sleeping has become a discussed issue in the U.S. Researchers investigated co-sleeping in parenting books published in the United States. They found 28% of authors advocated co-sleeping. In comparison, 40% of them opposed co-sleeping in infancy and early childhood (Ramos & Youngclarke, 2006).

At the same time, some anthropologists independently criticized the normativity of solitary sleeping for infants, and they indicated the biological advantages of infant-mother bedsharing with a series of research (Ball et al., 2019; Barry, 2019; McKenna et al., 2007). Researchers especially emphasized the young human infant's need for touch and proximity as the most immature-born primate (McKenna & McDade, 2005; McKenna et al., 2007). They suggested that night-time separation leads to intensive distress in infants based on primate studies that show the life-threatening effects of short separations on young primates (McKenna et al., 2007). Researchers supported this hypothesis. Middlemiss et al. (2011) found that a sleep training procedure with an extinction method did not decrease the high cortisol level of infants, but it reduced the mothers' cortisol levels. Bejiers et al. (2012) found co-sleeping in the first 6-months after birth predicted lower cortisol reactivity in stressful situations (in The Strange Situation procedure) at 12 months controlled for maternal sensitivity, infant attachment, and breastfeeding status. The cortisol levels in the morning and night-time have been lower for the children who co-slept with parents more than one year when compared with solitary sleeping children or the children who co-slept only in infancy (Waynforth, 2007). Besides, researchers speculated that bedsharing protects the baby from sleep apnea because it protects the mother and infant from long deep sleep (Marinelli et al., 2019, McKenna & McDade, 2005). They observed synchronized breathing patterns and fewer obstructive apneas in bedsharing mothers and infants (McKenna & Mosko, 1990; Mosko et al., 1996). Researchers found bedsharing facilitates breastfeeding more than twice when compared with solitary sleeping infants (Blair et al., 2010; Gettler & McKenna, 2011; McKenna et al., 2007).

Anthropologists who advocated bedsharing stated that solitary sleeping is common in WEIRD (Western, educated, industrial, rich, and democratic) societies (Ball et al., 2019, McKenna et al., 2007). Ball et al. (2019) stated that the advice of solitary sleeping in Western countries has become widespread after industrialization together with other baby care practices such as formula milk, sleep training, and breastfeeding schedules. McKenna et al. (2007) listed various reasons that solitary sleeping has become a norm in Western countries. They referenced the historians who noted the Catholic church forbade bedsharing to prevent infanticides (Stone, 1977, as cited in McKenna et al., 2007), and they speculated that this event had persisting effects. They also explained the impact of individualism, the fear of sexual exposure, and the formula-use (McKenna et al., 2007). Infants who are breastfed wake more often than infants who are fed with formula (Elias et al., 1986; Schmid et al., 2011), and breastfeeding mothers share the bed with infants frequently for convenience (Ball, 2002; Salm-Ward, 2015). Therefore, McKenna and Gettler (2007) indicated that bedsharing is related to breastfeeding. Following this, Haig (2014) emphasized modernization and opened to discussion the advice of extended breastfeeding regarding the night-wake problem and the well-being from an evolutionary perspective.

On the other hand, some assessed these discussions from a sociological viewpoint. They suggested that the infants' sleep has become a problem because society has not become egalitarian (Hochshild, 2003; Howson, 2018). Hochschild (2003) discussed that women were alone in domestic labor and caregiving responsibilities despite working outside the home. She stated that there is a "care deficit" in developed countries. Howson (2018) interpreted sleep training methods, breastfeeding schedules, or co-sleeping advice as solutions to the women's burden on care and work. She claimed that the problem is political, not medical, and she added that sleep training or co-sleeping advice assumes the mothers and children are vulnerable. She noted that these polarised solutions cause moral judgments on mothers such as "the bad mother who left her baby cry" or "the bad mother devoting herself to the child." Differently, Striley and Field-Springer (2013) pointed to the

effect of breastfeeding discourse on mothers. They explained that there have always been "the bad mother polices" who determine the "good (or "perfect") mother.

Similarly, Halley (2007) discussed the co-sleeping debate in her book, "Boundaries of Touch" from both sociological and psychological viewpoints. She summarized the two opposite extreme views about co-sleeping. She mentioned two discourses: The first one is the *masculine-oriented approach* centered on individualism. The second one is the naturalistic approach centered on the relationship between the child and the mother. She discussed Ferber's book, "*Solve Your Child's Sleep Problems*" (Ferber, 1985) as the representative of the masculine-oriented approach, and she debated Sears's book of "*Nighttime Parenting: How to Get Your Baby and Child to Sleep*" (Sears, 1985) as the representative of the naturalistic approach. Halley (2007) criticized Ferber's opinions on touch. She stated that Ferber's masculine-oriented method perceives "the good touch" as dangerous, uncontrollable, even incestuous. She also criticized Ferber's opinions about separation anxiety. She claimed that Ferber proposed a strict way of eliminating separation anxiety, although he admitted that children normally have separation anxiety. Halley (2007) criticized Sears's ideas in terms of that they are heteronormative. She criticized the concept of "natural maternal instincts." She emphasized that "maternal instincts" could have ambivalent feelings and attitudes. She discussed that Sears gave the women a "good mother role," and he fostered gender roles such as "the mothers should be at home and the father should make money." Similarly, Sadeh et al. (2011) criticized the promotion of co-sleeping as the ideal way, and they wrote that both advising co-sleeping and advising solitary sleeping is paternalistic. They addressed the distress of parents who did not seem satisfied with co-sleeping.

Mother-Infant Bedsharing: The Issue of SIDS

The debate on co-sleeping has been continued over different topics for different ages. Co-sleeping in infancy has been discussed in sudden infant death syndrome (American Academy of Pediatrics, 2016; Marinelli et al., 2019). Sudden infant death syndrome is defined as "a sudden, unexpected, and unexplained death of an infant" (Krous et al., 2004). Room sharing has been found to be reducing the

risk of SIDS by as much as 50% (Blair et al., 1999; Mitchell & Thompson, 1995). However, literature about the relationship between bedsharing and SIDS has controversial evidence (Mileva-Seitz et al., 2017). They found that bedsharing is risky unconditionally (Carpenter et al., 2013). Researchers mentioned the risks of accidental suffocation, head covering, overlaying in bedsharing (Byard, 1994; McIntosh et al., 2009; Mitchell et al., 1992). Vennemann et al. (2012) conducted a meta-analysis study with 2464 cases and 6495 controls. They showed that none of the studies had found a protective effect of bedsharing, and all studies found an increased risk in bedsharing. The study, including 1472 cases and 4679 controls, showed that bedsharing significantly increases the risk for SIDS regardless of the described risky conditions such as smoking, bottle feeding, alcohol, and drug-using (Carpenter et al., 2013). Therefore, bedsharing has been identified as a risk for sudden infant death syndrome in infancy, while room sharing has been advocated for infant care by the American Academy of Pediatrics (AAP, 2016).

On the other hand, some researchers emphasized bedsharing conditions as what poses the risk of SIDS rather than bedsharing itself (Blair et al., 1999, Garstang et al., 2020). They emphasized alcohol use, smoking, co-sleeping on the sofa as risky conditions in bedsharing (Blair et al.; 2009; Garstang et al., 2020).

Others indicated that bedsharing protects the baby as an evolutionarily natural practice increasing the survival chance of the infant (Marinelli et al., 2019). McKenna et al. (1990) speculated that solitary sleeping could increase the risk of SIDS. He stated the highest chances of SIDS are being an infant and living in an industrialized place (McKenna et al., 2007). The prevalence of SIDS has been low in Eastern countries which bedsharing is common (Nelson et al., 2001). McKenna et al. (2007) stated that infants need to learn and remember breathing; bedsharing provides infants to breathe with the arousal coming from their mothers. Considering the other positive effects of bedsharing in infancy (e.g., synchronize breathing, breastfeeding, cortisol regulation, protecting from deep sleep), the safe conditions of bedsharing are specified (UNICEF, 2019).

1.1.3. Parental Attitudes Towards Sleeping Arrangements

Allport (1935) defined "an attitude" as "a mental and neural state of readiness (p.810)." In contemporary psychology, the concept of the attitude was described as the feelings, beliefs, or behaviours that evaluate the "attitude object." An attitude object can be an object, event, group, person, place, thing, symbol, or act (Ajzen, 2001; Eagly & Chaiken, 1993).

Co-sleeping is a cultural phenomenon that the parents have different attitudes towards it. These attitudes have been changed through history and across cultures. Macro-level factors like the media, the ideas of the experts, and culture influence the parental attitudes towards co-sleeping (Chung & An, 2015; Haig, 2014; Thoman, 2006, McKenna et al., 2007). These macro-level factors interact with the micro-level factors such as personality, family dynamics, and personal experiences in developing the attitudes (Germo et al., 2007; Germo et al., 2009; Tikotzky et al., 2010). The effect of micro-level factors in co-sleeping is vital in investigating within-culture differences in children's sleeping arrangements. Ramos (2001) examined the individualism-collectivism scores of co-sleeping mothers and solitary sleeping children's mothers. Results showed that other factors determined the sleeping arrangements, not individualism-collectivism. She found a weak negative correlation between individualism and the frequency of solitary sleeping and a weak negative correlation between collectivism and the frequency of co-sleeping.

Attitudes towards sleeping arrangements had not been included in the quantitative studies until the 2000s. However, mothers have been asked for their beliefs, reasons, and motivations for child sleep arrangements in some qualitative studies. Researchers found some themes on co-sleeping indicating positive parental attitudes towards co-sleeping (Ball, 2002, Chianese et al., 2010; Haggerty, 2015; Hanks & Rebelsky, 1977). The parents who participated in these studies stated that breastfeeding is more convenient when they co-sleep; they sleep better when sharing the bed with the infant (Ball, 2002; Chianese et al., 2010). The parents reported that the children come to the parents' bed to feel secure, and co-sleeping nurtures the family (Hanks & Rebelsky, 1977). Some parents reported that it is a

tradition (Chianese et al., 2010). The mothers also mentioned their negative attitudes towards bedsharing. “Bedsharing derogates privacy, bedsharing is difficult to give up and leads to dependency” (Joyner et al., 2010), “solitary sleeping provides the independency of the child, and it reduces night fears, co-sleeping is a risk for sexual awareness of the children, co-sleeping is not convenient after pre-school years” (Rahimian et al., 2017) were the negative themes on mothers’ reflections about co-sleeping.

In Turkey**,** Baskale and Turan (2017) investigated the mothers’ reasons for bedsharing in their research of bedtime rituals of 0-24 months old infants. The results showed that 58% of mothers reported that they co-sleep to meet their child’s need immediately, 13% of them said they share the bed to reinforce their bond with the infant, 13% of them reported that they co-sleep to make the child feel secure, and 13% of them addressed the sleep difficulties of the infant.

Keller and Goldberg (2004) developed a self-report scale named “Parental Sleep Attitude Scale (PSAS)” to measure parental attitudes towards bedsharing and parental attitudes towards solitary sleeping. They included items like “Children will lose trust in their parents if they cry at night and the parents don't respond to the crying.”, “Having a 6-month-olds sleep alone is a great way to encourage their independence.”, “Bedsharing prevents a couple from experiencing intimacy and privacy.”. Positive parental attitudes towards bedsharing have been found to be related to the practice of co-sleeping (Dwyer, 2016; Keller & Goldberg, 2004; Germo et al., 2007, Song, 2010).

1.1.3.1. Intentional Co-Sleeping and Reactive Co-Sleeping

The difference between reactive co-sleeping and intentional co-sleeping has been discussed in the literature (Ramos et al., 2007; Mileva-Seitz et al., 2016). Firstly, Lozoff et al. (1984) mentioned that co-sleeping is usually a result of the child’s refusing to go to sleep. Sometimes, it is a usual kind of sleeping arrangement that all family members preferred in the U.S. Researchers used different descriptions for reactive co-sleeping and intentional co-sleeping. They indicated that intentional co-sleeping is a preference accompanied by positive attitudes towards co-sleeping, while reactive co-sleeping occurs due to the child’s sleep

problems (Madansky & Edelbrock, 1990; Ramos et al., 2007). Madansky and Edelbrock (1990) noted that reactive co-sleeping is more common in Western countries.

This distinction has been included in some studies in the 2000s. Researchers asked parents the reason for co-sleeping to determine whether the co-sleeping practice is reactive or intentional in their studies (Ramos, 2001; Ramos et al., 2007). Firstly, Ramos (2001) asked a question about the effect of the child's sleep difficulties in the practice of co-sleeping. The mothers' answers indicated the reason for co-sleeping as the child's sleep difficulties were categorized under "reactive co-sleeping." The answers of mothers showing "the reason for co-sleeping is not the child's sleep difficulties" were categorized under "non-reactive" co-sleeping. She found that mothers of reactive co-sleeping children were less satisfied with the child's sleeping arrangement than the mothers of the solitary sleeping group. However, the satisfaction scores of non-reactive co-sleeping did not differ from other groups (Ramos, 2001). Later, Ramos et al. (2007) asked mothers the nature of co-sleeping. The "reactive co-sleeping group" included the mothers who reported the reason for the co-sleeping as the child was not able to sleep alone. The "intentional co-sleeping group" included the mothers who said that they believed the best arrangement was co-sleeping for them. Reactive co-sleeping has been more common for toddlers. Ramos suggested that separating beds is a norm for toddlers rather than infants (Ramos et al., 2007).

Differently, some researchers used the rising time of co-sleeping to define reactive and intentional co-sleeping. Firstly, those who co-sleep for most of the week and more than half of the night are considered co-sleepers. They described reactive co-sleeping as the children's returning to the parents' bed following a period of solitary sleeping. (Hayes et al., 2007; Keller & Goldberg, 2004). Instead, they described the term "early co-sleeping," which referred to the practice of co-sleeping throughout infancy and at least in a part of toddlerhood. Intentional co-sleeping and early co-sleeping indicated similar characteristics. Keller and Goldberg (2004) stated that early co-sleeping families practice co-sleeping as a choice. Mothers of early co-sleeping children had more positive attitudes towards

co-sleeping than reactive co-sleeping children (Keller & Goldberg, 2004). Researchers stated that mothers of early co-sleeping children were satisfied with the sleeping arrangements of their children more than the mothers of reactive co-sleeping children (Germo et al., 2007). However, Seitz et al. (2016) suggested that reactive/intentional distinction is fluid, and parents sometimes prefer and enjoy co-sleeping, described as "reactive."

Ramos et al. (2007) indicated that the lack of the differentiation between reactive co-sleeping and intentional co-sleeping causes methodological problems in correlational studies. According to researchers, the mixed evidence about the relations between sleep problems, psychological problems, and co-sleeping might be explained by the distinction of reactive/intentional (or early) co-sleeping (Ramos et al., 2007; Mileva-Seitz et al., 2016). Ramos (2001) indicated that mothers of reactive co-sleeping children reported more bedtime resistance and night wake problems than the mothers of solitary sleeping children and the mothers of non-reactive co-sleeping children, and the mothers of solitary sleeping children reported fewer sleep problems than co-sleeping children. According to parental self-report, Keller and Goldberg (2004) found that reactive co-sleeping children had more bedtime resistance than early co-sleeping and solitary sleeping children. Mindell et al. (2010) found that co-sleeping was associated with sleep problems in Caucasian children, not in Asian children. In another study with parental self-report, co-sleeping was related to frequent night waking and bedtime resistance in lower SES Caucasian children and higher SES African American children (Lozoff et al., 1996).

Moreover, the nature of co-sleeping affects the behavioural outcomes of sleeping arrangements. Keller and Goldberg (2004) reported that early co-sleeping children who co-slept with their parents throughout their infancy and toddlerhood showed more autonomous behaviours (e.g., ability to dress himself/herself, playing alone with a book or toy, working on the problems with playmates) than solitary sleeping children and reactive co-sleeping children in preschool ages. In another study, researchers found significant associations between co-sleeping and empathy for the children whose maternal attitude towards co-sleeping was positive (Narvaez et al., 2013).

On the other hand, the relationship between parental emotional factors and the nature of the practice of co-sleeping has not been well examined. Maternal separation anxiety was found to be higher in the mothers of early co-sleeping and reactive co-sleeping children than the mothers of solitary sleeping children (Dwyer, 2016). In a study, mothers of early co-sleeping children had higher scores on autonomy support than the mothers of reactive co-sleeping children and the mothers of solitary sleeping children (Keller & Goldberg, 2004).

1.1.4. Sleep Problems of the Young Children

1.1.4.1. Normal Toddler Sleep

Extended scientific research about the sleep habits of infants and children has been conducted since the 1980s. Typical developmental changes of sleep behaviours, the average sleep durations, the bedtime and the wake time, the naps, the night-time awakenings of the infants and the children have been examined. In behavioural sleep research, the sleep diaries and the actigraphy recordings are used for the measurement of the sleep/wake circles (circadian rhythms). The sleep diaries include parents' daily reports of their children's bedtimes, wake times, night-time awakenings for a period. The actigraph is a watch-shaped device that records circadian rhythms. Studies have found information about normative sleep behaviours using these measurements with large samples. Later, several self-report scales were developed for the measurement of sleep habits and sleep problems of children (Horne & Biggs, 2013).

The range of normal sleep behaviour of toddlers is wide. However, the average sleep behaviours of toddlers in industrialized societies are stated as follows:

Sleep Durations: Studies estimated different sleep durations for normal toddler sleep. Toddlers' average nap duration and night-time sleep duration decrease with age. The sleep durations of children have shown differences across cultures. Mindell et al. (2010) showed that the *average night sleep duration* of 12-36 months old children is approximately 10 hours in PC (Predominantly Caucasian) countries while it is about 9 hours in PA (Predominantly Asian) countries. The same study reported that *the average bedtime* is one hour later in PA countries than PC

countries. They found that the average nap duration is more extended in PA countries.

In the large sample study that Sadeh et al. (2009) conducted, they found the *average night-time sleep duration* as 10.3 hours for 18-24 months old and 10 hours for 24-36 months old children. They reported *the average nap duration* as 2.19 ± .67 for 18-24 months and 1.89 ± .95 for 24-36 months. In China, researchers said the *average night sleep duration* was 9.83 for 18 months old children, 9.75 hours for 24-36 months old children, and 9.52 for 36 - 48 months old children. They found longer nap durations than the studies with American and Swiss participants (Xiao-na et al., 2009).

In Turkey, most studies have been conducted with infant subjects. Little information about toddlers exists. The evidence has been closer to PA countries. Karacal (2010) has found the average sleep durations as 10.57 for night sleep, 2.50 for a nap, and 13.07 in total for 10-36 months old children. The average sleep duration has been found as 9.52 hours for 36-72 months old preschool children (Ozvurmaz & Calisir, 2018). Tasdemir and Temel (2018) reported that the average bedtime of infants was one hour later than the American sample, like PA countries.

Night-time awakenings: Night-wakes have been found to be common: According to the study that Jenni et al. (2005) conducted, 20% of 12-48 months old Swiss children wake up at least once a night, and more than 50% of 4 years old children wake up at least once every week. In another study with mothers of 2,000 Norwegian toddlers, 54% of mothers reported their children waking up every night at least one time (Hysing et al., 2016).

On the other hand, Crowell et al. (1987) found that 64% of American children, whose ages ranged between 12 and 36 months, sleep through the night 5 to 7 nights each week. Blair et al. (2012) reported that 51% of 18-24 months old English children sleep through the night while 43% of them wake up at 1-2 times every night, and 7% of them wake up three or more times. The same study indicated that 50% of 24-36 months old children sleep through the night, 44% of them wake up 1-2 times at night, and 5% wake up three or more times (Blair et al., 2012).

Mindell et al. (2010) reported that 12-36 months old children's average number of waking per night is 1.70 in PA countries, and their average number of waking per night is 1.13 in PC countries. The average night-wake duration of the toddlers is short. A study with 10.000 Australian children reported the average night wake duration as 4.4 minutes for 24 months old children and 3.8 minutes for 36 months old children (Price et al., 2014).

Kurt et al. (2018) indicated that 8.9% of 0-36 months old Turkish infants do not wake at night, 20.4% of them wake once a night, 24.9% of infants wake two times at night, 45.8% of them wake at night more than two times according to mothers' self-report. Tasdemir and Temel (2018) carried out the reliability and validity study of The Brief Infant Sleep Questionnaire (BISQ: Sadeh, 2004) and The Daily Sleep Log (DSL; Sadeh, 2004)." They reported that the average number of the night wakes in the 0-36 months old Turkish sample was 2.03 in the DSL, 2.50 in the pre-test of BISQ, and 2.41 in the post-test of BISQ, which are higher than Sadeh's study (2004) with the American sample.

Karacal (2010) has found that 68.7% of 10-36 months old young children wake at night. When preschool children were investigated, researchers reported 50.9% of 36-72 months old children wake at night (Ozvurmaz & Calisir, 2018). The average frequency of night wakes in preschool-age was 1-2 (Gultekin & Temel, 2020).

Bedtime routines and transition to sleep: In Western societies, bedtime routines such as bathing, reading a book, singing to the child, good-night kisses are common. In non-industrial societies, children fell asleep when they were sleepy. In the Mediterranean countries, bedtime routines exist but are less common in comparison with the U.S. (Jenni et al., 2005). The bedtime routines have been more common in educated parents compared with parents with low education levels (Covington et al., 2019; Hale et al., 2010).

The young children's conditions of sleep transition vary. Sadeh et al. (2009) reported that 64% of toddlers transitioned to sleep in a crib alone, 15% of toddlers transitioned to sleep in their parents' bed, 11% of toddlers transitioned to sleep in a crib with parental presence, 12% of them fell asleep by holding, 6-10% of them fell

asleep by watching television, 5% of them fell asleep by nursing, and 7% of them transitioned to sleep by bottle-feeding in their study with a large American/ Canadian sample. In 24-36 months, the rate of nursing to sleep was 2%, and bottle feeding to sleep was 2%.

When the Eastern societies were studied, the results have changed. Co-sleeping, bottle-feeding, and nursing rates have been increased. One study that included data from 17 countries reported Eastern sleeping characteristics as follows: 34% of children fell asleep by bottle feeding, 27% of children in their parent's bed with the parents, 22% of children sleep alone, 14% of them initiate sleep by holding, 11% of them initiate sleep by rocking, 9% of children begin to sleep by nursing, 8% of them fell asleep by watching TV at 18-23 months. Moreover, 44% of children fell asleep in their parents' bed with the parents, 28% of children by bottle feeding, 14% of them alone in their own bed/crib, 12% of them initiate sleep in their crib with the parental presence, 13% watch TV to sleep, 10% of children fell asleep by holding, 6% of them by rocking, 5% of the children initiate to sleep by nursing at 24-36 months (Mindell et al., 2010).

In Turkey, researchers conducted a study in Karabuk Province, and they reported that 29.3% of 18-24 months old children fell asleep on their own, 26.8% of them by parental presence, 7.3% by nursing, 17.1% by rocking, 2.4% by the transitional object, and 7.3% by the pacifier. Additionally, 29.6% of 24-36 months old children fell asleep independently, 32.1% by parental presence, 3.7% by nursing, 24.7% by rocking, 1.2% by the transitional object, and 2.5% by pacifier (Kahraman & Ceylan, 2018). Another study indicated that 71.6% of 12-36 months old children need help to initiate sleep (Karacal, 2010). In infancy, 91.7% of babies fell asleep by breastfeeding or bottle-feeding, 62% of them fell asleep by rocking (Boran et al., 2014).

Transitional object or sleep aid (e.g., teddy bear, doll, blanket) is more common in Western societies than other societies. For example, researchers reported that 18% of Korean infants (Hong & Townes, 1976), 31% of Italian children in urban areas; and 5% of Italian children in rural areas (Gaddini, 1970), and %54 of American children used the transitional objects (Litt, 1981).

1.1.4.2. Definitions of Sleep Problems: Dyssomnias

The boundary line of the normal toddler sleep and the problematic toddler sleep is not sharp. Young children cannot report that they had a sleep problem, so their parents' and the health care professionals' concerns about the child's sleep are the determinants of a sleep problem. The child's and the family's daily functioning are important to indicate the child's sleep behaviour as a problem. On the other hand, the sleep behaviours which negatively affect the child's growth, immune system, daily functioning, and health are defined as a sleep problem (Davis et al., 2004).

Sleep problems are divided into two main types: Dyssomnias and parasomnias. Dyssomnias are sleep problems in which the child has difficulty in falling and staying asleep at night. In parasomnias, the child's sleep is interrupted by physiologic or behavioural acts like sleep walking, nightmare, and sleep terror (Davis et al., 2004).

The American Academy of Sleep Medicine published a detailed manual to diagnose sleep disorders (The International Classification of Sleep Disorders Diagnostic and Coding Manual – Revised, ICSD-2, 2005). Several sleep disorders with early onset were included in this manual. The most common dyssomnias seen in young children are Limit Setting Disorder, Sleep Onset Association Disorder, Adjustment Sleep Disorder, Food Allergy Insomnia, and Nocturnal Eating (drinking) Syndrome.

Limit Setting Disorder is defined as difficulty initiating sleep, refusing sleep occurring at bedtime and after night-time awakenings. In Limit Setting Disorder, children may want an extra drink, take a bath again, listen to another story, take a screen time, or they say that they fear. For Limit Setting Disorder, it is required not to have any other medical problem or sleep disorder. Polysomnographic monitoring shows standard sleep quality and duration after the sleep initiated in Limit Setting Disorder (ICSD-2, 2005). Sleep Onset Association Disorder is defined as the difficulty in starting sleep without certain conditions such as bottle-feeding, sucking, rocking, etc. For Sleep Onset Association Disorder, it is required not to have any other medical problem or sleep disorder. Polysomnographic monitoring

shows normal sleep quality and duration after the sleep initiated (ICDS-2, 2005). In Nocturnal Eating (Drinking) Syndrome, young children could not sleep without drinking or eating (ICDS-2, 2005).

In the third version of The International Classification of Sleep Disorders Diagnostic and Coding Manual, the separate diagnosis of Limit Setting Disorder, Sleep Onset Disorder, and Nocturnal Eating Syndrome were excluded. They were included under the diagnoses of "chronic insomnia disorder," "short-term insomnia disorder," or "other insomnia disorder" (ICDS-3, 2014). However, these classifications are still used for behavioural interventions of sleep problems (Owens et al., 2017).

There are some other sleep disorders that are seen in young children. Adjustment Sleep Disorder is defined as a sleep disturbance temporally related to acute stress. Food Allergy Insomnia is defined as a sleep disturbance that occurs dependent on an allergic reaction. Post-traumatic hypersomnia occurs after a traumatic event. Obstructive sleep apnea syndrome is described as "the repetitive episodes of upper airway obstruction that occur during sleep, usually associated with a reduction in blood oxygen saturation." Other sleep problems are parasomnias such as night terror, nightmares, confusional arousals (ICDS-2, 2005).

Manuals have not included quantitative metrics for sleep problems of children. Some researchers have defined quantitative descriptions of sleep problems. Richman (1981) described the symptoms for 1-3 years old children's sleep problems as night waking more than three times, wake duration longer than 30 minutes, and co-sleeping existing more than 5 nights per week and for a 3-month duration (Richman, 1981). Gaylor et al. (2001) used the criteria of that night waking more than two times per week and lasted for 1 month and more than 20 minutes parental involvement at sleep onset more than two times per week and lasted for 1 month. Sadeh (2004) defined research criteria of infant sleep problems as "night waking three or more times per night," "night wake duration that more than one hour," and "less than 9 hours of total sleep time".

1.1.4.3. Different Approaches to the Sleep Problems of Young Children

Researchers showed varied parental opinions about which sleep behaviours of toddlers are normal and which of them are problematic. (Crowell et al., 1987). Sadeh (2004) defined a subjective criterion of "sleep problem" as the bedtime resistance and the night waking that the parents need to stop the behaviour by intervention. Lozoff et al. (1985) described sleep problems as the struggle about sleep between parents and the child that occurs more than three times a week.

Researchers indicated that it is normal for toddlers to wake up at night two to six times physiologically. However, they emphasized that children with sleep problems have trouble falling asleep again after waking up at night (Avis et al., 2004; Gaylor et al., 2001; Goodlin - Jones et al., 1997). Researchers found that most children return to sleeping independently by self-soothing at 6 months (Gaylor et al., 2001; Goodlin - Jones et al., 1997). Zuckerman et al. (1987) showed that 41% of 8 months old infants who could not sleep independently had sleep onset issues at 36 months. Therefore, the lack of self-soothing has been both the criteria and the predictor for dyssomnias by many researchers (Anders et al., 1992; Goodlin-Jones et al., 1997; Touchette et al. 2009).

The children's sleep problems (e.g., sleep onset problems, waking at night) have been associated with parenting stress, the depressive mood of parents, and parental fatigue (Bernier et al., 2013; Meltzer & Mindell, 2006; Sadeh et al., 2011). Some researchers emphasized that the sleep problems of the children, including co-sleeping, impair the parent-child relationship and the family's functioning (Eckerberg, 2004; Meltzer & Montgomery-Downs, 2011). Some researchers addressed the sleep associations as the reason for the sleep problems. They stated that infants who can sleep alone in the crib at the beginning of the night sleep could soothe themselves through the night (Gaylor et al., 2001). These associations are the parental involvements like rocking, holding, nursing, co-sleeping, etc. They explain that the children associate sleeping with parental involvement, leading to an inability to sleep without parental support (Mindell et al., 2010). Some described nursing/feeding to sleep or co-sleeping directly as a sleep problem (Bayer et al., 2007). Thus, some researchers recommended behavioural interventions to teach the

child or infant sleep through the night by self-soothing. These behavioural interventions aim to decrease parental involvement at sleep time by extinction, graduated extinction, bedtime routines, and bedtime fading (Fuantes-Vega et al., 2017; Gradisar et al., 2016; Sadeh et al., 2009; Touchette et al., 2005). Sadeh and Anders (1993) suggested a multi-level intervention model including behavioural interventions, maternal psychodynamics (i.e., separation anxiety), and specific medical screenings.

Some researchers suggested family-centered or parent-centered interventions to treat young children's sleep problems (Goldberg et al., 2013; Thome & Skuladottir, 2005). Thome and Skuladottir (2005) found that the family-based interventions resulted in better infant sleep and better parental mental health. Goldberg et al. (2013) emphasized that the anxious or depressed mothers interpreted the common infant sleep characteristics as more problematic. They noted the parental perceptions of sleep problems are related to the parents' dispositions like the sensory thresholds, but mental health symptoms may increase with the perceived sleep problems. They stated that some parents have unrealistic expectations about infant/toddler sleep, and giving the correct information about the normal infant/toddler sleep to the parents is essential. They stated that interventions aiming for better parental mental health are necessary for the infants' sleep problems (Goldberg et al., 2013).

On the other hand, some researchers stated that the young children's night-time signals for parental involvement and their need for support to fall asleep were pathologized in Western culture. Researchers reported that 39% of 3 years old children had dyssomnias (Zuckerman et al., 1987). Researchers indicated 25-41% of 1-4 years old children wake up at night and have bedtime resistance (Lam et al., 2003). Some proposed that the cause of the sleep problems is the social expectation that the children should sleep alone (Blunden et al., 2011).

McKenna et al. (2007) emphasized the relationship between breastfeeding and night wakes. Elias et al. (1986) found that children who continued to be breastfed did not sleep through the night until 2 years old, so she discussed the infant/toddler sleep norms regarding extended breastfeeding. However, some

researchers found that frequent night wakes and breastfeeding is not associated after 9 months (Brown & Harries, 2015; Mindell et al., 2012). They found that feeding or nursing to sleep is associated with a higher number of night wakes (Mindell et al., 2012).

Worthman and Melby (2002) wrote that night-time crying is seen rarely in non-industrialized cultures where the children co-slept with their parents. Sleep problems might have a historical dimension like the sleeping arrangements. Stearns et al. (1996) noted that child-rearing books have started to write about children's sleep as a problem in the 1920s. In their review, Stearns et al. (1996) mentioned the experts' strict ideas about child sleep. Watson proposed that children would not have natural night fear; they could stay alone at night in the 1920s. He explained, "They do not need holding, rocking to sleep, and their need is a sleep schedule." (Watson, 1928, as cited in Stearns et al., 1996). Stearns et al. (1996) wrote that the issue of sleep problems had risen in these years in the texts. On the other hand, the children's sleep duration has been a concern since 19th in Western texts. In the 19th, it was not medicalized, but writers noted that the children's sleep duration is shorter by reason of modern life (Johnson, 1899, as cited in Matricciani et al., 2012).

The relationship between the parental perceptions of sleep problems and the culture is not clear. In the studies that included middle-to upper-class American samples, parents who did not see co-sleeping as a problem also reported that their children's sleep behaviours were not problematic (Germo et al., 2009; Keller & Goldberg, 2004; Ramos, 2001; Ramos et al., 2007). Similarly, some researchers indicated that parents of Caucasian children describe the child's sleep behaviour as a problem more frequently than parents of African American children (Lozoff et al., 1996). On the contrary, Sadeh et al. (2011) conducted a study about the parental perceptions of sleep problems with 29,287 parents of infants and toddlers in 17 different countries. The parents who lived in Asia significantly reported higher numbers of perceived problematic sleep behaviours than the parents who lived in Europe or North America reported in this study.

In Turkey, the parents seem to be perceived the children's sleep difficulties as problematic. Researchers conducted a large sample study including participants

of all Turkey regions and indicated that 21.3% of the mothers of 10-48 month-old children reported that their child had sleep difficulties (Karabekiroglu et al., 2013). Sadeh et al. (2011) reported the rate of parental perceptions of sleep problems changed in a range of 11-79% across different cultures. In Turkey, Boran et al. (2014) used the same scale, and they found 33.9% of parents perceived sleep problems in their 0-36 month-old infants. Similarly, 29-31% of parents of 0-36 month-old infants reported that their child has a sleep problem (Kahraman & Ceylan, 2018).

1.1.4.4. Co-Sleeping and Sleep Problems

Research evidence of associations between sleep problems and co-sleeping is mixed. Some studies found negative associations between sleep problems and co-sleeping, while some found positive associations between sleep problems and co-sleeping. Researchers underlined the bidirectional relationship between sleep problems and co-sleeping. They speculated that co-sleeping is usually a result of sleep problems rather than being a cause in Western cultures (Madansky & Edelbrock, 1990; Ramos & Youngclarke, 2007). Mindell et al. (2009) found that sleep onset behaviours of the parents mediated the relationship between sleep problems and co-sleeping. They noted that more parental presence predicted more sleep disruption.

Many studies which were conducted with samples from both Western and Eastern societies showed that co-sleeping children had higher numbers of night wakes than solitary sleeping children (Coulombe & Reid, 2012; Covington et al., 2018; Latz et al., 1999; Liu et al., 2014). In Turkey, Karacal (2010) reported that co-sleeping children had higher numbers of night wakes than solitary sleeping children. On the other hand, some found that co-sleeping was not associated with night wakes (Byars et al., 2012; Jenni et al., 2005; Shinohara & Kodama, 2012; Iwata et al., 2013). Researchers found that solitary sleeping children had more nightmares than co-sleeping children had. (Mahendran et al., 2006). In India, solitary sleeping was associated with more sleep problems (Murthy et al., 2015).

Anders et al. (1983) also noted that the parents consistently reported less frequency of night waking than video recordings showed. Thus, it can be proposed

that co-sleeping mothers notice more night wakes. Researchers compared the self-report and actigraphy results, and they found that the number of the night wakes was higher in co-sleeping children than solitary sleeping children only in self-reports, not in actigraphy records (Volkovich et al., 2015).

1.1.5. Attachment and the Sleeping Arrangements of the Young Children

1.1.5.1. Attachment Theory

Attachment theory originated from that the human baby seeks proximity to an attachment figure to feel secure. The infant's search for proximity is an evolutionary adaptation that provides the survival of the offspring (Bowlby, 1958, 1982). Attachment theory also included the idea that the child needs a safe base to explore the environment (Bowlby, 1969).

John Bowlby (1907-1990) realized the negative impact of prolonged, early separations on mental health when he worked with the juvenile delinquents in the children's clinic. He observed the separated children's anxious or detached behaviours (Ainsworth & Bowlby, 1991). In the meantime, Bowlby examined animal studies (e.g., Harlow, 1958; Lorenz, 1939) and influenced from ethology. These studies had shown that animal infants need mothers for touch and contact. Bowlby explained that the need for protection and warmth are the elements of the baby's interest to the mother (Bowlby, 1958). He described some signal behaviours of infants such as "sucking, clinging, following, crying, and smiling." These behaviours were attachment behaviours that provide the proximity and warmth between the infant and the mother (Bowlby, 1958). Bowlby interpreted the functions of attachment behaviours as turning the familiar and safe one, avoiding the dangerous and unknown, and reducing the stress (Bowlby, 1969).

Mary Ainsworth (1913-1999) conducted mother-infant observation studies. She examined the mother-infant interactions affecting the attachment behaviours of infants. Ainsworth conducted laboratory studies named "The Strange Situation" with 12-20 months old infants after one year of home observation. The Strange Situation Procedure determined the secure and insecure infants. Insecure infants were divided into "ambivalent/resistant infants" and "avoidant infants." This procedure consisted of a series of separations and reunions of the mother and the

infant. Secure infants distressed when the mother left the room, interested with the stranger when the mother was there, explored the environment using the mother as a secure base, exhibited positive emotions when the mother turned. Ambivalent/resistant infants were distressed when the mother left the room, showed avoidance behaviour to the stranger, cried more, and did not explore the environment; they did not get calm when the mother turned. Avoidant infants did not show distress when the mother left the room and did not show interest when their mother turned (Ainsworth et al., 1978). Later, Main and Solomon (1990) added the fourth group, named "disorganized infants," who exhibit disorganized behaviours such as dissociation, freezing with confusing, mixed strategies of avoidant and resistant infants.

Secure infants exhibited more cooperation with both their caregivers and other adult figures, and they explored the environment; their interaction with the caregivers was harmonious at home (Ainsworth et al., 1978). She explained that these infants could use their caregivers as a secure base. Ainsworth et al. (1978) suggested that it resulted from the internalization of the responsive caregiver. The repeated positive experiences provided a secure attachment. Ambivalent infants cried more, and they had difficulty getting calm; they were over-dependent on their caregivers at home. Ainsworth et al. (1978) stated that these infants were not sure about their mothers' responsiveness, and their attachment system was overly activated to get a response from their caregivers. In turn, the mothers of ambivalent infants were inconsistent in their responsiveness (Ainsworth, 1979; Ainsworth et al., 1978). Ainsworth (1979) also explained the ambivalent infant's experiences of bodily contact. Their experiences of bodily contact were also not always positive. Ainsworth (1979) emphasized that the duration and frequency of body contact did not foster secure attachment; the positive, congruent, and accurate time of holding the baby was important. The infants responded holding with a positive manner responded positively being put down; the mother's positive manner and the infant's positive response were associated in bodily contact (Bell & Ainsworth, 1972, as cited in Ainsworth, 1979). Mothers of avoidant infants were rejective to the infants'

signals, and they felt irritated when the infants cried. Their experiences of bodily contact mostly were not affectionate (Ainsworth et al., 1978).

Ainsworth (1967) introduced the concept of "maternal sensitivity" that affects the infants' attachment security (as cited in Bretherton, 2013). Maternal sensitivity expressed the degree to which the mother was responsive to the baby's signals. Maternal sensitivity includes many elements such as correct interpretation of signals, encouragement of exploration, cooperation, accepting emotions, and non-intrusiveness (Ainsworth et al., 1974). Researchers showed that measures of maternal sensitivity had a moderate effect size in the prediction of the infants' attachment style (De Wolff & van IJzendoorn, 1997). Later, attachment researchers added some other predictors of infant attachment, and they developed new concepts or new measures to investigate maternal responsiveness. An important concept is parental mentalization which means understanding that the child has their own mental states and reflecting the child's mental states like thoughts and feelings (Fonagy et al., 1991). Parental responsiveness and mentalization affect the infant's attachment (van IJzendoorn & Bakermans-Kranenburg, 2019).

Ainsworth (1967) noted that attachment is expressed by behaviour patterns, but the attachment is not behavioural patterns. She emphasized that attachment is the internalized expectations, feelings, memories, and wishes. Bowlby (1969) introduced the concept of the "Internal Working Model." He described the "Internal Working Model" as the representations and expectations about the self and relationships (Bowlby, 1969).

Schore (2000) stated that attachment theory is an affect regulation theory. He has proved that the infants' affect regulation capacity is affected by their interactions with the caregivers (Schore, 2001).

Beebe and Lachmann (2014) explained that the infant learns to regulate himself or herself by the mutual affect regulation processes. They indicated that the infant shares the responsibility of the caregiver-infant interaction. They emphasized the co-regulation and self-regulation processes. The caregiver and infant respond to each other with contingency, they coordinated each other, and they self-regulate themselves during communication. The behaviours of the caregiver and infant were

influenced by both their own prior behaviour and the partner's behaviours. Self-contingency is described as the correlation between one's own behaviours (prior to the next), while interactive contingency is described as the coordination between partners (Beebe et al., 2010). Researchers suggested the "optimal midrange model," indicating a moderate level of interactive contingency predicts secure attachment. This shared communication gives the infant the sense of being known, he or she can affect the other, the infant finds herself or himself as an agent in a predictable world, and she or he can regulate herself and himself by the internalized interactive regulation processes (Beebe & Lachmann, 2014).

1.1.5.2. Adult Attachment

According to the attachment theory, the early relationships with attachment figures have a life-long impact (Bowlby, 1969, Weiss, 1982). The internal working models continue to influence one's experiences in relationships from childhood to adulthood (Bartholomew, 1990; Bowlby, 1969; Main et al., 1985).

The adult attachment has been researched in two distinct ways. The first method explores one's mental representations of childhood experiences. The second method focused on one's romantic relationships (Bartholomew & Shaver, 1998). The first method was developed by George, Kaplan & Main (1984). They developed The Adult Attachment Interview (AAI) is a semi-structured interview that includes open-ended questions about the interviewee's thoughts, feelings, memories that related to her/his parents, and childhood experiences. The AAI was first used to determine the attachment style (secure, dismissing, preoccupied, unresolved) of parents who had young children (Main, Kaplan, & Cassidy, 1985). In the AAI, the attachment types of the individuals are determined by assessing the participants' narratives. (George et al., 1984).

The second method in understanding adult attachment approaches the individual's romantic relationships. Weiss (1975) suggested that adults need attachment figures in a similar way the infants need. He indicated that adults feel lonely in the lack of attachment figure, they need an accessible attachment figure when they are distressed, and they get anxious when the attachment figure is out of reach. Hazan and Shaver (1987) referenced Weiss's approach; they suggested that

adults activate the attachment system in their romantic relationships. They indicated that the secure base is the romantic partner in the romantic relationships. Hazan and Shaver (1987) developed a self-report questionnaire in which they asked the participants to choose the one closest to their own experience from three descriptions of different romantic relationship experiences. One of them represented avoidant attachment and described difficulty in intimacy. One of them represented ambivalent attachment and described a worry about abandonment and a need for closeness. The third one described a comfortable and intimate presence in romantic relationships, representing secure attachment.

Later, Bartholomew (1990) indicated that Hazan and Shaver's (1987) avoidant attachment style states difficulty and distress in being close to others, while the dismissing attachment style in the AAI indicated a denial of the distress. Thus, he suggested four attachment styles rather than three (Bartholomew, 1990). Bartholomew and Horowitz (1991) described two different avoidant attachment styles: Fearful and dismissing. In fearful attachment, the individual feels insecure and vulnerable, while in dismissing attachment, the individual tends to avoid close relationships with an emphasis on independence. They developed a self-report questionnaire named "Relationship Questionnaire (RQ)." They used internal working models as the baseline and included self and other representations in the four questions that represent the attachment styles (Bartholomew and Horowitz, 1991).

In contemporary romantic adult attachment research, the two-dimensions model of adult attachment has been used (Fraley et al., 2000, Gillath et al., 2016). One dimension is attachment anxiety which refers to the hypersensitivity in the attachment system. Fear of abandonment, the feeling of self-worthlessness, seeking proximity are indicators of high attachment anxiety. One dimension is attachment avoidance which refers to the deactivation of the attachment system. Being uncomfortable in close, intimate relationships and self-competence are indicators of high attachment avoidance (Brennan et al., 1998, Gillath et al., 2016). Brennan et al. (1998) developed The Experience in Close Relationship Scale (ECR) using

the two-dimensional model. Later, Fraley et al. (2000) developed a revised version of this scale named ECR-R.

Problems in the self-report scales measuring adult attachment have been discussed. First, the researchers stated that it is not clear which relationship experiences are investigated in self-report scales. They emphasized that a person's experiences can vary in different close relationships. They can have different internal working models in their romantic relationships, peer relationships, and parents. The internal working models can also change across various romantic partners (Fraley et al., 2011).

1.1.5.3. Adult Attachment and Parenting

Bowlby proposed "The Caregiver System" to explain the parental behaviours like protecting, feeding, caring, etc., based on the same ethological approach with the attachment system (Bowlby, 1988). He described the synchrony between the parental behaviours and the infant's behaviours (Bowlby, 1988). However, this synchrony is breakable (Jones et al., 2015).

Parents' own childhood experiences affect how they interact with their children. Main and Hesse (1990) indicated that infants trigger the parents' attachment representations and parents response to infants according to their internal working models. Haft and Slade (1989) reported that dismissing mothers did not understand the negative affect in their infants, preoccupied mothers could not attune their infants' signals, projected their anxieties, and secure mothers could usually attune the infants a wide affective range. Cassidy and Kobak (1988) explained that dismissing mothers minimizes the infants' attachment signals by rejecting them to be less triggered. Cassidy and Berlin (1994) suggested that preoccupied mothers reinforce the child's dependency by their inconsistent responses.

Many researchers found a relationship between the infant's attachment style in Strange Situation and the mother's attachment style in the AAI (van Ijzendoorn, 1995). Secure infants were likely to have secure parents, and ambivalent infants were likely to have preoccupied parents, avoidant infants were likely to have dismissing parents (Main et al., 1985; van Ijzendoorn, 1995).

Researchers found an association between parental attachment security and emotional availability, maternal sensitivity, and parental reflective functioning (Biringen et al., 2000; Pederson et al., 1998; Slade et al., 2005). As expected, maternal attachment security also plays a role in the child's affect regulation. Maternal attachment security predicts better emotion regulation in preschool children (Feldman et al., 2011). Researchers found that children of insecure mothers had more difficulty in regulating fear at 24 months old (Coppola et al., 2015).

Volling et al. (1998) used Hazan and Shever's (1987) self-report scale to examine attachment security, and they found that secure parents feel more competent with their parenting than insecure parents. However, they did not find any relationship between the parents' attachment styles and the infants' attachment security and observed parenting behaviours. They suggested that self-report scales measuring romantic attachment might not relate to parenting behaviours as The Adult Attachment Interview is related.

On the other hand, many researchers used self-report scales, and they found associations between parenting-related constructs and adult attachment (Cohen et al., 2011; Goodman et al., 1997; Millings et al., 2012; Rholes et al., 2006; Selcuk et al., 2010). For example, researchers found attachment-related avoidance is associated a less parental sensitivity (Edelstein et al., 2004; Mills-Koonce et al., 2011; Selcuk et al., 2010). Researchers found an association between attachment-related anxiety and conflicts in the parent-child relationship (Selcuk et al., 2010). Others found permissive and strict parenting behaviours and attachment insecurity is associated (Millings et al., 2012). The parents with more attachment avoidance reported less satisfaction with parenting, and they valued parenting less (Cohen et al., 2011; Rholes et al., 2006). Researchers reported an association between maternal separation anxiety and mothers' insecure attachment (Mayseless & Scher, 2000; Vasquez et al., 2002) Mayseless and Scher (2000) found this relationship only for attachment avoidance.

Researchers found that mothers' romantic relationship quality, mothers' romantic attachment style, and affective relationship with the child interacted. Mothers with high ambivalence score felt less close to their children when their

marriage quality was higher. They felt closer to their children when their marriage quality was lower. Mothers with higher avoidance scores felt less close to their children regardless of the marriage quality (Rholes et al., 1995).

1.1.5.4. Attachment Related Constructs in Different Cultures

Cassidy and Berlin (1994) stated that mothers of ambivalent infants were over-involved when the infant attempt to explore. They suggested a caregiving model of preoccupied mothers that emphasizes dependency and prevents autonomy. However, Rothbaum, Weisz, et al. (2000) stated that this model of preoccupied parenting is Western-biased. They noted that a typical Japanese mother-child relationship has some common characteristics with this enmeshed relationship, and it has not been dysfunctional or maladaptive in Japan. They suggested that attachment theory is universal with its evolutionary concepts, but security manifests itself differently across cultures.

Researchers included autonomy as a predictor and indicator of secure attachment (Bernier et al., 2014). Rothbaum, Weisz, et al. (2000) stated that the concept of competence differs in the West and the East since the parental goals are different for these cultures. In collectivist cultures, social harmony has been valued rather than expressiveness and autonomy (Triandis, 1995). Thus, mental health, competence, and the sense of security did not associate with autonomy in these cultures (Rothbaum, Weisz, et al., 2000). Moreover, the emphasis on exploration differs across cultures. For instance, Japanese infants showed less exploratory behaviour than American infants, and they went towards their mothers more than American infants (Bornstein et al., 1990). Moreover, maternal sensitivity has been observed in different forms across cultures. Reducing distress, physical proximity have been the expressions of maternal sensitivity in collectivist cultures as the most common regulation behaviours. The mothers respond to the infants before they expressed their needs (Feldman et al., 2006; Rothbaum et al., 2011).

Attachment styles have been examined in many cultures using the same measures. Supporting the attachment theory, secure attachment has been found to be the most common attachment type across different cultures. However, the manifestation of insecurity has changed across cultures. Many studies using several

measurement tools of attachment from Strange Situation procedure to self-report scales showed that ambivalent/preoccupied attachment had been found to be more common in collectivist cultures while avoidant attachment has been found to be more common in individualist cultures (Schmitt, 2010; van Ijzendoorn & Bakermans-Kranenburg, 2010; Van IJzendoorn & Kroonenberg, 1988).

Friedman et al. (2010) proposed the "cultural fit hypothesis" to use the self-report scales measuring adult attachment. They suggested that attachment avoidance would be the predictor of relationship problems in the collectivist cultures rather than attachment anxiety. They suggested that higher attachment anxiety is culturally congruent in collectivist cultures unless the scores are not extremely high. Therefore, they indicated that higher attachment avoidance would associate with mental health issues rather than attachment anxiety. In Turkey, many studies supported the cultural-fit hypothesis. Children's attachment security (Sumer & Kagitcibasi, 2010) and maternal sensitivity (Selcuk et al., 2010; Sumer et al., 2016) were negatively associated with attachment avoidance, but not attachment anxiety in Turkish samples. However, some studies showed that attachment anxiety of parents also predicted children's developmental outcomes such as trait anxiety, academic achievement, and mothers' fear of child's safety (Sumer et al., 2016; Sumer & Harma, 2015).

1.1.5.5. Attachment and the Young Children's Sleep

Since co-sleeping mainly occurs because of sleep problems in Western societies, most researchers have assumed infants' sleep difficulties lead to co-sleeping (Bayer et al., 2007; Richman, 1981). Researchers noted that solitary sleeping is the norm in Western society. They conducted research according to this norm (Sadeh et al., 2010). Therefore, the literature on the relationship between sleep difficulties and attachment will be presented first.

Anders (1994) stated that the child's sleep time is a separation time, and the waking time is a reunion time. The attachment system becomes activated at bedtimes, and the infant is distressed at sleep time depending upon the attachment system (Keller, 2011). Researchers have approached the sleep-related signal behaviours of infants differently. Some interpreted the signal behaviours of the

infant at night as developmentally normal behaviours (Keller, 2011; Scher & Dror, 2003). Some suggested that these behaviours are an indicator of attachment insecurity, and they emphasized the self-soothing capacities of secure children (McNamara et al., 2003; Anders, 1994; Sadeh & Anders, 1993). However, the age of the infant was not clear in these interpretations. Anders (1994) suggested that the inability of self-soothing can be an indicator of insecure attachment after 8-months. McNamara et al. (2003) suggested that lack of self-soothing can be an indicator of insecurity for 15 months old toddlers. Researchers proposed that ambivalent-attached infants and toddlers get more distressed at bedtime, and they showed more signal behavior to reach their caregivers when they wake up at night. They suggested that the avoidant infants and toddlers tend to show fewer signal behaviours at night, and the secure ones also exhibit fewer signal behaviours and settling problems due to their mental representation of a soothing, predictable caregiver (McNamara et al., 2003).

Research findings of attachment and infant sleep are mixed. McNamara et al. (2003) conducted a large sample study to test the relationship between night wakes and attachment security with 15 months toddlers. They found that toddlers with ambivalent attachment had a greater number of night wakes than toddlers with avoidant attachment, but securely attached toddlers did not differ in night-wakes from insecure ones. Infant sleep was measured according to the mothers' self-report. Scher (2001) found that night wakes are common for all infants, and attachment did not affect night wakes at 12 months. Researchers indicated the infant's settling difficulties were related to dependency, not security. (Scher, 2001; Scher & Asher, 2004). They found that secure-dependent infants (the B4 group who exhibited a higher level of proximity seeking and contact maintenance and who could explore the environment in the Strange Situation) had a higher level of settling problems than insecure-ambivalent infants (Scher & Asher, 2004). Conversely, Zentall et al. (2012) found that secure infants had fewer night wakes than ambivalent infants, and dependency did not affect the children's sleep at 14 months. Night wakes were calculated from parental self-report. Little research has been conducted about toddler sleep and attachment. Morell and Steele (2003) found

ambivalent attachment predicted higher numbers of night-wakes in 24 months. They used self-report sleep measures. Weinraub et al. (2012) did not find any relationship between mother-infant attachment and sleep disturbance in their large sample study with 0-36 months infants. Simard et al. (2013) found a relationship between attachment and night wakes only for mothers' self-report, not for actigraphy. It was not the waking of the baby that was associated with attachment, but the baby's awakening the mother. Avoidant infants aroused their mothers less, and ambivalent infants aroused more in comparison to secure infants.

Researchers also examined the relationship between infant sleep and maternal emotional availability as well as maternal sensitivity. They found that the mothers' self-reported pleasure in their interaction with their infants and night-time sleep problems were positively correlated (Scher & Dror, 2003). Scher (2001) used The Emotional Availability Scales (EA, Robinson & Emde, 1993), which includes a coding system of the observational data, and she reported similar findings. She found that the child's higher level of responsiveness and involvement in the dyadic daytime relationship is positively correlated with the child's greater number of night wakes. Similarly**,** Higley (2007) reported that 12 months old secure and insecure infants showed no significant differences in the frequency of night waking. She found the night-time interactions between mothers and infants showed a difference between secure and insecure infants. Mothers of secure infants were found to be more responsive. She noted that they picked up quickly and soothed their children when they signaled at night (Higley, 2007). However, the mothers' emotional availability at bedtime affected the children's sleep differently compared with the daytime emotional availability of mothers. Teti et al. (2010) reported that 0-24 months old young children whose mothers were more emotionally available at bedtime had less frequency of night waking, and they had fewer disruptions at bedtime. Additionally, they reported that the mothers' actions, such as close contact, quiet book-reading, were not related to the child's sleep resistance and sleep quality. Another study showed the importance of the child's age in the relationship between sleep disturbance and attachment-related factors. Tetreault et al. (2016) found a positive relationship between maternal sensitivity and sleep

quality for 2-4 years old children, but they did not find this relationship for 12-18 months old infants.

Clinicians reported that the most common issue about sleep problems is the separation anxiety of mothers and infants in their clinical practice (Daws, 1989**;** Sadeh & Anders, 1993). Bowlby (1959) wrote that the underlying cause of excessive separation anxiety of caregivers is the caregiver's past experiences of loss and rejection. Daws (1989) stated in her book "*Through the Night"* that the separation and the child's solitary sleeping is a significant aim for some mothers, while it is a suffering experience that triggers past losses and rejections for some mothers. The study investigating the relationship between maternal attachment and child sleep found that the mothers' attachment insecurity is significantly related to the child's sleep behaviour. Benoit et al. (1992) reported that all mothers of toddlers with sleep disorders showed insecure attachment patterns in the Adult Attachment Inventory (AAI) compared to the control group, in which 57% of mothers showed insecure attachment patterns. This study used Richman's criteria (1981) for sleep problems and included coming to the parental bed (a kind of reactive co-sleeping) as a sleep problem. Similarly, researchers showed that the mothers' history of sleep problems and attachment style was linked to the length of the infant's night wakes (Reem et al., 2014). However, some studies with the non-clinical sample used Relationship Questionnaire (Bartholomew & Horowitz, 1991) that measures maternal attachment insecurity in their romantic/close relationships. They did not find any relationship between a 9-15 month-old infant's sleep disturbance and maternal attachment (Burnham et al., 2002; Scher & Dror, 2003).

The caregiver's own childhood experiences also affect their sleeping arrangement choice. In a past cultural practice named kibbutz childcare, infants and children living in children's houses. The children met their parents in the evenings. Then, their parents took the children back to the children's house at night. The infants and children slept at the children's house (Aviezer et al., 2002). Sagi et al. (1994) found that the prevalence of insecure attachment was high in communal-raised children. Tikotzky et al. (2010) found that parents raised in children's houses co-slept with their 4-30 months old children more than the parents raised in their

parents' home. Another study found the same finding for the mothers of 0-6 years old children (Aviezer & Scher, 2013).

The relationship between sleeping arrangement and attachment or attachment-related factors were investigated in various studies. Jones et al. (2020) tested the relationship between maternal attachment and room-sharing for 6 months old infants. They found no relationship between the two. Keller (2008) reported no association between 18 months old toddlers' attachment style and their sleeping arrangements. Another study showed that the daily positive interaction between mother and infant predicted stable sleeping arrangements (Taylor et al., 2008).

1.1.6. Maternal Anxiety and the Young Children's Sleep Arrangements

Anxiety is an emotion that includes unpleasant feelings like uneasiness and worries; somatic complements like blood pressure, perspiration; ruminated or worried thoughts related to anticipated events or uncertainty (Kazdin, 2000).

Spielberger et al. (1983) described two forms of anxiety. State anxiety can be temporal, acute and could be based on current conditions, stress factors, and the state of mind. Trait anxiety is the form of continuous or chronic anxiety and indicates personal proneness to feel anxious. These two forms of anxiety emerged in Cattell and Scheier's factor analysis studies (1958, 1961) of anxiety and neuroticism (as cited in Barratt, 1965). Parental anxiety can be measured by some self-report scales such as The Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990); The State-Trait Anxiety Inventory (STAI: Spielberger et al., 1970), The Beck Anxiety Inventory (BAI: Beck, et al., 1988), etc. The State-Trait Anxiety Inventory used in this study measures separately the general anxiety level and the state anxiety developed based on stressful conditions.

Researchers indicated that parental anxiety is a risk factor for children's excessive anxiety (Borelli et al., 2015; Fellow & Smith, 2000). Children's anxiety also affected the distress in the environmental context. Researchers suggested that the young children's sense of emotional security is related to familial context, and it is affected by the parents' distress (Cummings & Davies, 1996; Davies et al., 2002).

Dahl (1996) suggested that transition to sleep requires a sense of security both emotionally and physically. The young children's sleep duration and quality are affected by the parents' distress (Keller, & El-Sheikh, 2011). Many studies have found that parental mental health and child sleep are related. Maternal depression, anxiety, and infant sleep problems, including reactive co-sleeping, have been found to be associated (Lozoff et al. 1985; Lam et al., 2003; Seifer, 2011; Thome & Skuladottir, 2005; Thunstrom 1999). Toddler sleep problems and maternal anxiety have been related to co-sleeping children (Covington et al., 2018). Some emphasized the effect of the mothers' distress in the interpretation of the infant sleep. Goldberg et al. (2013) found that mothers with high levels of anxiety or depression perceived more sleep problems than mothers without mental health issues. Similarly, Teti and Crosby (2012) found that depressive mothers misinterpreted the infants' cues at night-time, and they exhibited overinvolvement behaviour.

Maternal trait anxiety is also related to maternal separation anxiety that describes the unpleasant feelings of worry, sadness, and guilt in the short-term separation of the mother and the young children (Hock et al., 1989). Bowlby wrote that separation from the infant also distresses the caregiver (Bowlby, 1969). A smooth transition to sleep requires a regulation mechanism in the caretaker-child dyad (Dahl, 1996). Maternal separation anxiety plays a role in the regulation of the infant's distress at sleep time. Researchers found that a lower level of maternal separation anxiety is associated with a low frequency of night waking, less parental involvement, and less physical proximity with the infant's sleep at night (Scher, 2008; Scher & Blumberg, 1999). Anxious mothers may want to persist proximity during sleep time. Researchers reported that maternal separation anxiety level was significantly higher in co-sleeping infants' mothers than solitary sleeping infants' mothers (Dwyer, 2016; Keller, 2008).

However, co-sleeping does not always associate with maternal mental health issues. The culture is a crucial variable to assess co-sleeping. Researchers found that co-sleeping was associated with more sleep problems, maternal ambivalence, and more family stress in only Caucasian families, not in African

American families (Lozoff et al., 1996). Similarly, a cross-cultural study conducted with Dutch, Moroccan, and Turkish families showed that maternal mental health problems and co-sleeping are associated only in Dutch families (Luijik et al., 2013). The distinction between reactive and intentional co-sleeping in Western societies is also remarkable to assess co-sleeping. Parental overcontrol and overprotection behaviour has been related to parental anxiety (Bögels & van Melick, 2004; Kalomiris & Kiel, 2016; Möller et al., 2015). Co-sleeping has been suggested to be associated with overprotection and overinvolvement (Morelli et al., 1992). Conversely, Keller and Goldberg (2004) reported that intentional (early) co-sleeping mothers supported the autonomy of the children more than the mothers of solitary sleeping and reactive co-sleeping children, and they indicated that early co-sleeping mothers had fewer scores on maternal control. Researchers have been suggested two explanations for these findings. First, they have suggested the night-time proximity provides daytime autonomy. Second, they have suggested that early co-sleeping mothers are more permissive about their child's choices, and they encourage the autonomy of the child.

Parental Anxiety and Sleep: The COVID-19 as a Stressor:

The Coronavirus disease (COVID-19) began to spread over the world in the first months of 2020. World Health Organization (WHO) declared the COVID-19 disease as an international public health emergency and a global pandemic in March 2020 (Cucinotta & Vanelli, 2020). COVID-19 threatened public health, and it caused many deaths. To prevent the spreading of the virus, many people stayed at home, schools, many industries, and workplaces were closed. Psychological and socio-economical stressors caused by social isolation and health threat have affected people's mental health (Hessami et al., 2020). In the COVID-19 pandemic, the population anxiety scores have been increased significantly in women (Özdin & Özdin, 2020). Studies showed that the children's anxiety level and the parents' anxiety level are linked after disasters (Green et al., 1991; MacFarlane, 1987).

The sleep quality, sleep duration, and sleep practices have been influenced by pandemic conditions like exposure screen and blue light, increased levels of anxiety, lack of physical activity (Altena et al., 2020; Becker & Gregory, 2020).

Insomnia rates have been increased (Voitsidis et al., 2020; Zreik et al., 2020). Zreik et al. (2020) reported that mothers' sleep quality has reduced, but the children's sleep quality, duration, and sleeping arrangements have not changed for most young children. Liu et al. (2020) found that children's sleep durations have become longer, their bedtimes have become later, and their sleep disturbances have reduced. They also found that the co-sleeping rate has been increased for preschool-age children. On the contrary, other researchers reported that young children's sleep problems have increased with the pandemic (Bruni et al., 2021; Lecuelle et al., 2020).

1.1.7. Temperament and the Young Children's Sleep

1.1.7.1. Temperament

Psychologists have described temperament according to four main approaches. In the behavioural approach, Thomas and Chess (1987) conceptualized temperament as the dispositional behavioural tendencies independent from the motivations or abilities. They explained that these behavioural tendencies could interact with the motivations or abilities, but they exist independently. They gave an illustration of the little child's clinging behaviour in the playroom to the mother. They noted the child's separation anxiety is the effect of motivation. The child's weak motor development is the effect of the ability, and the child's avoidant reactions to the playroom are the effect of the temperament in this behaviour (Goldsmith et al., 1987). They conducted the New York Longitudinal Study (Thomas et al., 1960) and concluded that temperamental characteristics of the children were stable from infancy to adolescence. Based on the interviews with the parents, they distracted nine dimensions of temperament. These dimensions are activity level, rhythmicity, the intensity of reaction, adaptability, approach/withdrawal, attention span/persistence, threshold of responsiveness, mood, and distractibility. Activity level indicated the intensity of motor activity (e.g., speed, frequency, level). The rhythmicity indicated how regular the biological activity (e.g., sleep) of the child is. The intensity of the reaction was the intensity of the infants' responses like crying, laughing. Adaptability was the infant's style in adapting to new environments and situations. The approach/withdrawal was the dimension of the infants' reaction to the new stimuli. Attention span was the

duration that the infant persists in her or his involvement in an activity. The threshold of responsiveness was the infant's perceptual sensitivity. The mood was the infant's behaviours indicating his or her emotions. Distractibility was the infant's alteration of his or her behaviour via an external stimulus. Based on the combinations of these dimensions, they formed three main temperament types: Easy, Difficult, and Slow to Warm Up. Easy infants were adaptable, had regular rhythms, and usually had positive moods. Difficult infants were less adaptable, had more negative moods, and were irregular in their biological activities. Slow-to-warm-up infants were shy and less active (Thomas et al., 1968). Some researchers revised these types as "resilient," "under controlled," and "overcontrolled", some renamed difficult temperament as "resistance to control" or "high maintenance" (Shiner et al., 2012).

In a criterial approach, Buss and Plomin described temperament as "the inherited personality traits which appear in infancy." They noted that they did not include the infant characteristics, which do not contribute to personality in their temperament description (e.g., rhythmicity in sleep or feeding) (Goldsmith et al., 1987). They identify four dimensions of temperament from the New York Longitudinal Study: Emotionality, activity, sociability, and impulsivity. Later, they excluded impulsivity because of the strong effect of the environment in impulsivity. The emphasis was on the genetics in criterial approach, and this approach has contributed to behavioural genetics research, including genotype-environment interaction studies (Shiner et al., 2012).

In this emotion regulation model, Goldsmith and Campos (1980) defined temperament as "the differences in experiencing and expressing emotions." (as cited in Goldsmith et al., 1987). They emphasized the psychophysiological differences in reactivity. Rothbart and Derryberry (1981) described temperament as "relatively stable, primarily biologically based individual differences in reactivity and self-regulation." They defined reactivity as "the responsiveness to the external and internal changes," and they defined self-regulation as "the effortful control to modulate the responses" (Rothbart & Bates, 2007). They added psychophysiological states and experience-related changes to their temperament

description (Goldsmith et al., 1987). Because self-regulation has continued its development through infancy and early childhood, they suggested the stability of temperament is moderate in regulation-related dimensions. At the same time, it is more stable after toddlerhood (Putnam et al., 2008).

Temperament has been measured by caregiver reports, self-report scales, home observations, and laboratory studies (Rothbart & Bates, 2006). Researchers discussed the validity of parental report scales in terms of item ambiguity and bias, and they suggested the combined use of parental report and observation in assessing the child's temperament (Kagan, 1998). On the contrary, Rothbart and Bates (2007) advocated that caregiver-report measurement of temperament is useful because parents know the child's responses to many different stimuli well. Parental self-report scales have been found to be moderately or strongly correlated with observational measures (Matheny et al., 1987; Thomas et al., 1963, as cited in Rothbart & Bates, 2006). Still, researchers discussed the problems of caregiver reports in temperament research (Goldsmith, 1996). The possibility of subjective interpretation of the items, the effect of the mind state of the parents when they respond to the scale, the parental bias and the effect of the parent-child relationship, the absence of an objective, stable base for comparison has been described as the problems in the parental self-report scales of temperament (Bates & Bayles, 1984; Goldsmith, 1996).

Carey (1970) developed the first caregiver report temperament scale for infants using New York Longitudinal Study. Later, Fullard and Carey (1984) developed The Toddler Temperament Scale indicating both the nine dimensions of the temperament and easy, difficult, and slow - to warm up temperaments. Rothbart (1981) aimed to reduce the overlapping dimensions in the scale above and developed The Infant Behaviour Questionnaire (IBQ). The IBQ included dimensions of activity level, smiling and laughter, fear, distress to limitations, soothability, and duration of orienting. As a follow-up of the IBQ, Goldsmith (1996) developed Toddlers Behavior Assessment Questionnaire (TBAQ) to measure the toddlers' temperament via parental self-report. The dimensions were activity level, pleasure/positive affect, social fearfulness, anger proneness, and

interest persistence. As a follow-up, Putnam et al. (2006) introduced The Early Childhood Behaviour Questionnaire (ECBQ). Putnam et al. (2006) used the Rothbart's approach (1981) for this scale and included behavioural and regulatory processes in their scale questions in addition to the TBAQ's emotion-focused questions. The dimensions in the ECBQ were activity level, attention focusing, fear, frustration, high- and low-intensity pleasure, perceptual sensitivity, positive anticipation, sadness, soothability, discomfort, impulsivity, inhibitory control, shyness, attention shifting, motor activation, and sociability. In the current study, the ECBQ dimensions of activity level, fear, frustration, perceptual sensitivity, and soothability were assessed for the children.

1.1.7.2. Temperament and Parenting

The parental behaviours, parent characteristics, and the child's temperament interact with each other. The child's difficult temperament could evoke negative responses in the parents (Bates et al., 2012). Environmental factors also affect the child's temperament. Twin studies showed the effect of environment on temperament (Goldsmith et al., 1997). Researchers showed that the regulation processes of the parents influence the child's self-regulation capacities and brain development (Kopp, 1982; Schore, 2001).

Kiff et al. (2011) suggested a bidirectional transactional model of parenting and temperament. They explained that parents could reduce the children's negative reactivity while the child's negative reactivity could lead to angry or less sensitive responses at the parents. They indicated that the parents' reinforcement of positive responses of the child could change the child's reactivity. Some correlation studies showed the relationship between parenting behaviours and child temperament (Coplan et al., 2009; Kertes et al., 2009; Kochanska et al., 2004; Owens et al., 1998). However, the evidence has been mixed. Researchers found positive associations between parental warmth and positive reactivity (Kochanska et al., 2004), fear and parental warmth (Kertes et al., 2009; Kochanska et al., 2004), the child's shyness and overprotective behaviour of the parents (Coplan et al., 2009). Paulussen-Hoogeboom et al. (2007) reported that the child's negative reactivity and parental warmth are associated negatively only for low SES families. Kochanska et al.

(2004) found negative associations between the infants' anger/frustration and parental warmth. On the other hand, some researchers did not find an association between parental warmth and the child's self-regulation (Karreman et al., 2006). Some found low parental sensitivity predicted more fear responses at the child, controlling for the early fear response level of the children (Braungart-Rieker et al., 2010). Researchers also mentioned the shared genetic features explaining the relationship between parenting and child temperament (Dubi et al., 2008). Kiff et al. (2011) also suggested an interactional model which proposed the child's temperament moderates parenting behaviour.

1.1.7.3. Temperament and Sleep

Many researchers have found that the child's difficult temperament is related to the child's sleep difficulties (Atkinson et al., 1995; Carey, 1974; Jimmerson, 1991; Morell & Steele, 2003; Weinraub et al., 2012). Atkinson et al. (1995) indicated that parental reports of night-wake problems and the preschool children's difficult temperament assessed by the Toddler Temperament Scale were associated. The age of the child is important in assessing the correlates of night wakes. Hayes et al. (2001) investigated temperament and reactive bedsharing. They reported that bedsharing preschool children were more intense, less adaptable, and they had lower scores on the rhythmicity than solitary sleeping children, according to the caregiver report. Jimmerson (1991) reported that the toddlers with sleep problems were less adaptable than toddlers without sleep problems according to parental self-report.

Sensory sensitivity has been found to be related to settling difficulties of infants and toddlers (Appleyard et al., 2020; Vasak et al., 2015). The measurement tool of sensory profiles and sensory processing was used to measure the sensory sensitivities rather than temperament measures in these studies.

On the other hand, some researchers found no relationship between temperament and sleep difficulties of infants and toddlers (Carey, 1974; Hayes et al., 2001; Hayes et al., 2011). Carey (1974) found 6-12 months old infant's sleep problems were only associated with a low sensory threshold among nine

temperament dimensions. Hayes et al. (2011) found no relationship between temperament and sleep difficulties of the toddlers.

Researchers indicated that sleep problems had a stronger relationship with temperament than attachment for infants and toddlers (Morell & Steele, 2003; Weinraub et al., 2012). Troxel et al. (2013) found that insecure attachment is related to sleep problems only for children with difficult temperaments.

1.2. CURRENT STUDY

In Turkey, co-sleeping is prevalent for infants and toddlers. Studies reported the co-sleeping rate as 60-70% for toddlers and 30-50% for 3-6 years old children (Kahraman & Ceylan, 2018, Karacal, 2010). The rates also showed that the young children's sleeping arrangements are diverse. However, there has been no research investigating the toddlers' sleeping arrangements as the primary research subject in Turkey. This study aims to examine the sleeping arrangements of 18-48 months old toddlers.

Researchers stated that developmental factors such as night-time fears, separation-individuation, environmental factors such as sleep location, bed type, and parent's presence affect the toddler's sleep specifically (Honaker & Meltzer, 2014). On the other hand, parents' responses to children's sleep behaviors become more varied after the first year of life. Researchers showed that parents' opinions about which sleep behaviours of toddlers are normal and also problematic. (Crowell et al., 1987). First, the present study will examine the parental perceptions of sleep problems, the children's sleep onset behaviours, and the parental responses at night wake in different sleeping arrangements.

Fişek (1982) stated that the bond between mother-child is the most critical element in the traditional Turkish families rather than the bond between the couple. The child is closed to the mother both emotionally and hierarchically (Fisek 2018). The hierarchy has been weakened at some part in high SES families with the effect of the social change, but the emotional relatedness in the family structure has been stable in Turkey (Fisek, 2018). Therefore, co-sleeping may be intentional in many Turkish families. Moreover, attachment parenting (or natural parenting) has been

popular in Turkey (Sieben & Yildirir, 2020). It might be another factor contributing the practice of intentional co-sleeping in Turkey.

On the other hand, solitary sleeping has also been seen in Turkish families. Thus, reactive co-sleeping might also exist in Turkish families. This study also aimed to distinguish reactive and intentional co-sleeping to understand better the co-sleeping phenomenon in Turkish families. The variety of the toddler sleeping arrangements will examine in terms of sleep practices, maternal perceptions of sleep problems, and the psychological factors of maternal attitudes, maternal anxiety level, maternal attachment, and the child temperament. Additionally, the demographic factors will be investigated. The mothers' received criticism for the children's sleeping arrangements will be asked to gain some information about the effect of the co-sleeping debate on the mothers.

1.2.1. The Research Questions and the Hypotheses

The research questions and the hypotheses of the study were:

Research Question 1: What are the demographic factors related to the sleeping arrangements of children?

Research Question 2: What are the sleep practices of children in different sleeping arrangements?

Research Question 3: What is the relationship between the children's sleeping arrangements and the mothers' perceptions of sleep problems?

Research Question 4: Are maternal attitudes, anxiety level, and mothers' attachment anxiety/avoidance related to children's sleeping arrangements?

Hypothesis 1: Intentional co-sleeping and reactive co-sleeping children's mothers will have higher scores on their favourable attitude towards bedsharing and lower scores on their favourable attitude towards solitary sleeping than mothers of solitary sleeping children.

Hypothesis 2: Intentional co-sleeping children's mothers will have higher scores on their favourable attitude towards bedsharing and lower scores on their favourable attitude towards solitary sleeping than mothers of reactive co-sleeping children.

Hypothesis 3: Sleeping arrangements will be related to the mothers' attachment insecurity.

3.a. Reactive co-sleeping children's mothers will have higher attachment anxiety than intentional co-sleeping children's mothers and solitary sleeping children's mothers.

3.b. Reactive co-sleeping children's mothers will have higher attachment avoidance than intentional co-sleeping children's mothers and solitary sleeping children's mothers.

3.c. Intentional co-sleeping children's mothers will have higher attachment anxiety than solitary sleeping mothers.

Hypothesis 4: Mothers of intentional co-sleeping children and reactive co-sleeping children will have higher trait and state anxiety levels than solitary sleeping children's mothers.

Research Question 5: Are children's temperamental characteristics related to the children's sleeping arrangements?

Hypothesis 5: Sleeping arrangements of children will be related to the child's temperament.

5a. Reactive co-sleeping children will have higher scores on activity level, fear, frustration, and perceptual sensitivity than solitary sleeping children and early co-sleeping children.

5b. Reactive co-sleeping children will have lower scores on soothability than solitary sleeping children and early co-sleeping children.

CHAPTER 2

METHOD

2.1. PARTICIPANTS

In this study, 1260 parents volunteered to participate through online platforms. 135 participants were excluded because they did not meet the selection criteria for the child's age and being a mother who lived with a partner. 59 participants were excluded due to a severe chronic illness in the child's family members or atypical development. Finally, 11 participants were excluded due to the inconsistent data on the sleeping arrangement questions. The total number of participants remained 1055.

Mothers' age ranged from 21 to 48 years (M = 33.49, SD = 4.02). All of them were married or lived with their partner. The participants were from various regions of Turkey; 47.5% of the participants lived in The Marmara Region (N = 501), 21.6% of the participants lived in The Aegean or Mediterranean Region (N = 228), 17.7% of them lived in The Central Anatolia Region, (N = 187), 5% of them lived in The Black Sea Region (N = 53), 3.9% of them lived in The Eastern or Southeast Anatolia (N = 41), 3.9% of them lived abroad (N = 40). Regarding income level, 19.1% of the participants' monthly household income were beloved 2 minimum wages, whereas 24.2% of the participants' monthly household income were between 2-3 minimum wages and 56.8% of the participants' monthly household income were above 3 minimum wages. 92.6% of mothers lived with their nuclear family (N = 977), and 7.4% lived with their extended family (N = 78). Most of the mothers were well-educated. 31.5% mothers had postgraduate degrees (N = 332), 62.8% of them had bachelor's or college degrees (N = 663), 5.3% of mothers were high-school graduates (N = 56), and 0.4% of them were secondary school graduates (N = 4). Regarding their employment status, 50.3% of the mothers worked outside the home (N = 531), 13.4% worked from home (N = 141), and 36.3% did not work (N = 383). 33.5% of the mothers worked full-time or overtime (N = 353), 28.6% of the mothers worked part-time (N = 302), 1.6% of the mothers worked in shifts (N = 17) (See Table 2.1).

Mothers reported that 22.5% of the fathers had postgraduate degrees (*N* = 237); 64.1% of them had university or collage level education (*N* = 676), 12.1% of the fathers were high-school graduates (*N* = 128), and 1.1% of them were secondary school graduates (N = 4), 0.2% of them were primary school graduates (*N* = 2). 91.7% of the fathers worked outside the home (*N* = 967), 6.8% of the fathers worked from home (*N* = 72), and 1,5 % of the fathers did not work (*N* = 16). 78.7% of the fathers worked full-time or overtime (*N* = 831), 14.7% of the fathers worked part-time (*N* = 155), 4.9% of the fathers worked in shifts (*N* = 52) (See Table 2.1).

The children who were the subjects of this study via their mothers' self-reports had the age range of 18 to 48 months (*M* = 30.37, *SD* = 9.04), and their sex were 51.8% male (*N* = 547), 48% female (*N* = 506), 0.2% other (*N* = 2). 75.2% of them had no siblings (*N* = 793). 22.7% of them had one sibling (*N* = 239), 2.2% of them had two or more siblings (*N* = 23). Regarding their birth time, 8.6% of the children were preterm (*N* = 91), 91.4% of children were born after the 37th week (*N* = 964). 8.8% of them had a disease, surgery, or complication in the past (*N* = 93). 57.7% of children were looked after by their parents (*N* = 609), 20.4% of them were looked after by the grandparents or relatives (*N* = 215), 11.7% of them were looked after in day-care or the kindergarten, 10.2% of them were looked after by the care worker (*N* = 108) in working hours. 80.9% of the children had their own room or a shared room with their siblings (*N* = 853), whereas 19.1% of the children did not have room (*N* = 202) (See Table 2.2).

Table 2.1

Demographic Information of The Sample (Parents)

	N	Percentage
Mothers' Age (Years)	1055	
(Range = 21 to 48)		
(*M*= 33.49, *SD* = 4.02)		
Region		
Marmara	501	47.5
Aegean or Mediterranean	228	21.6
Central Anatolia	187	17.7
Black Sea	53	5.0
Eastern or Southeast Anatolia	41	3.9
Abroad	40	3.8
Family type		
Nuclear Family	977	92.6
Extended Family	78	7.4
Monthly Household Income		
Under ₺6000	201	19.1
₺6000 to ₺9000	255	16.9
Over ₺9000	599	43.2
Mother's Education		
Secondary School	4	0.4
High School	56	5.3
University/College	663	62.8
Postgraduate	332	31.5
Father's Education		
Primary School	2	0.2
Secondary School	12	1.1

Demographic Information of The Sample (Parents)- Continued

	N	Percentage
High School	128	12.1
University/Collage	676	64.1
Postgraduate	237	22.5
Mother's Working Status		
Working outside home	531	50.3
Working from home	141	13.4
Not working	383	36.3
Father's Working Status		
Working outside home	967	91.7
Working from home	72	6.8
Not working	16	1.5
Mother's Working Hours		
Full time or overtime	353	33.5
Part time	302	28.6
In shift	17	1.6
Not working	383	36.3
Father's Working Hours		
Full time or overtime	831	78.7
Part time	155	14.7
In shift	52	4.9
Not Working	16	1.5

Table 2.2

Child Characteristics

	N	Percentage
Child's Age (Months)		
18 - 24	310	29.4
24 - 30	225	21.3
30 - 36	191	18.1
36 - 42	173	16.4
42 – 48	156	14.8
Sex of Child		
Female	506	48.0
Male	547	51.8
Other	2	0.2
Number of Children in the Family		
Only child	793	75.2
Two children	239	22.7
Three or more children	23	2.2
Daily Care of Child		
Parents	609	57.7
Grandparents or Relatives	215	20.4
Day-care or kindergarten	123	11.7
Care worker	108	10.2
Birth		
After 37th week	964	91.4
Before 37th week (preterm)	91	8.6
Have a room	853	80.9
Not have a room	202	19.1

2.2. MEASURES

2.2.1. The Demographic Form (The Personal Information Form)

In the Personal Information Form, demographic information such as household income, age, education level was asked. Some questions about the child's developmental history and the general health of the family were included in the form.

2.2.2. The Sleep Practices Questionnaire (SPQ)

The Sleep Practices Questionnaire (SPQ) (Keller & Goldberg, 2004) was prepared to collect information from parents about sleep-related issues of young children. The questionnaire includes questions about the infant's sleep location over time, reasons for sleep arrangements, parental attitudes towards bedsharing and solitary sleeping, parental satisfaction with sleep arrangements, criticism about sleep arrangements the mother received, the frequency of night-time awakenings of the child, the frequency of several parental responses to the night-time awakenings of the child (e.g., nursing, bottle feeding, bedsharing, singing, etc.), the child's sleep initiation methods (e.g., nursing, rocking, etc.), the degree to which parent perceived problems with the child's sleep behaviours, and the parental opinions and experiences of the infant's sleep through the night. Most survey questions about sleep practices, including sleeping arrangements, were adapted from the SPQ in the current study. A question about transitional object use, and a question about the sleep quality of the child in the past (infancy), and three questions about the bedtime behaviours of the child were added to the survey.

The scale questions are single-item questions, and responses are arranged in a 5-point Likert scale (1: not at all satisfied; 5: definitely satisfied), and 5-point Likert scale questions were transformed into categoric variables in this study. The frequency of practicing bedtime routines had two categories, the answer of "often" and "always" were included in the "practiced bedtime routine" category, while other answers were included in the "not regularly practiced" category. Maternal responses to night wakes were transformed into categoric variables, and the answers of "sometimes," "often," and "always" were included in the "mother responds" category, which indicated that the mothers respond in that way sometimes to

always. Other scale questions were transformed into three categories of low, moderate, and high levels.

2.2.3. The Parental Sleep Attitudes Scale (PSAS)

Keller & Goldberg (2004) developed The Parental Sleep Attitudes Scale to assess maternal attitudes towards co-sleeping and solitary sleeping in their survey of The Sleep Practices Questionnaire (SPQ). It includes a 16-item 6-point Likert scale (1: strongly disagree; 6: strongly agree). The scale has two dimensions: 7 items for attitudes towards bedsharing and 9 items for attitudes towards solitary sleeping. Internal consistency was .84 for attitudes towards the bedsharing dimension and .90 for attitudes towards the solitary sleeping dimension. The sub-scales were negatively correlated with each other, $r = .73$.

The scale was translated into Turkish with the back-translation method. The back-translation method was used to maintain the meaning of the items equivalent between original and translated versions of the scale (Behling & Law, 2000). Brislin's classic back-translation model (1970) requires a team of translators (Brislin, 1970). Six translators and researchers were involved in the translation team for the translation of the PSAS. All translators were graduated from the English Language departments. One of them was Turkish-English bilingual. Firstly, two translators translated the PSAS into Turkish independently. Two translators compared the translated and original versions of the questionnaire to control the possible meaning changes in items. They made necessary changes in the Turkish translation for clarity. Another translator back-translated the Turkish translated version of the PSAS into English blindly. One bilingual translator compared the original and back-translated versions of the PSAS. The procedure repeated one time for the items with error, and another translator agreed that the original and back-translated scales have equivalent meanings.

Cronbach alpha values in this study were .74 for attitudes towards the bedsharing dimension and .81 for attitudes towards solitary sleeping dimensions. The subscales were negatively correlated with each other, $r = .37$.

2.2.3.1. Psychometric Properties of the Parental Sleep Attitude Scale (PSAS)

In the original scale, Keller and Goldberg (2004) conducted a Principal Component Analysis with Varimax rotation that extracted two components. The first component had 7 items (Attitude Toward Bedsharing) and the second component had 9 items (Attitude Toward Solitary Sleeping). The construct validity of the scale has not been available (Keller & Goldberg, 2004). The scale can be used as separate subscales or a single scale. High scores indicate a more favorable attitude toward solitary sleeping in the single scale form, and low scores indicate more favorable attitudes toward co-sleeping.

Firstly, the descriptive statistics for each item were examined. Item 2 and Item 4 were excluded because of high mean, low variance, and problematic skewness. There were no inter-item correlations above .70.

The Principal Component Analysis (PCA) was used to identify the factor structure. Firstly, the factorability of the 14 PSAS items was examined. Inter-item correlations were checked. All of 14 items correlated at least .30 with at least one other item, and Bartlett's test of sphericity was significant, $X^2(91) = 4691.80$, $p < .001$, confirming the factorability. The Kaiser-Meyer-Olkin measure of sampling adequacy was .869, above the recommended value of .60. The diagonals of the anti-image correlation matrix were over .5 except for Item 11. Finally, the communalities were above .3 except for Item 15. Then, Item 11 and Item 15 were excluded.

A Principal Component Analysis (PCA) was conducted using the 12 remaining PSAS items. Bartlett's test of sphericity was significant, $X^2(66) = 3729.74$, $p < .001$, confirming the factorability. The Kaiser-Meyer-Olkin measure of sampling adequacy was .866. Oblimin with Kaiser normalization is used as the method of rotation. Rotation converged in 5 iterations. 2 components with eigenvalues greater than 1.5 were extracted and explained 50% of the total variance. Item 14 was eliminated due to the multiple loading. The components with item-factor loadings are presented in Table 2.3. Differences between the original and the revised factor structure are presented in Table 2.4.

Table 2.3

Item-Factor Loadings of Parental Sleep Attitude Scale (PSAS)

Items	Factor Loadings	
	Factor 1	Factor 2
16. Children who sleep in their parents' bed will have a difficult time making the transition to sleeping in their own room.	0.791	
12. Bedsharing, if it goes on too long, is a habit that is hard to break.	0.790	
9. Bedsharing prevents a couple from experiencing intimacy and privacy	0.753	
10. Bedsharing prevents parents from getting a good night's sleep.	0.753	
13. Sharing a bed with children less than 2 years old is physically unsafe for them (i.e., they may accidentally suffocate, or accidentally roll or crawl off the bed).	0.650	
1. Parents try to get their children to sleep through the night on their own because it is convenient.	0.557	
5. Sleeping alone reduces 6-month-olds' sense of security.		0.757
6. 6-month-olds who regularly have to cry themselves to sleep are being neglected		0.701
8. Children have a hard time sleeping alone, as reflected by their bedtime struggles		0.700
7. Infants younger than 6 months may not yet be developmentally ready to sleep through the night		0.677
3. Having 6-month-olds sleep alone is a great way to encourage their independence		-0.598
Eigenvalue	3.88	1.81
Explained Variance	35.26%	16.45%

Table 2.4

Changes in the Factor Structure of the PSAS

Item Number	Factor in the Original Structure	Factor in the Revised Structure
PSAS16	1	1
PSAS12	1	1
PSAS9	1	1
PSAS10	1	1
PSAS11	1	-
PSAS13	1	1
PSAS14	1	-
PSAS15	1	-
PSAS6	1	2
PSAS3	2	2
PSAS5	2	2
PSAS7	2	2
PSAS8	2	2
PSAS1	2	1
PSAS2	2	-
PSAS4	2	-

The first component included 6 items and indicated a positive attitude towards solitary sleeping. The second component included 5 items and indicated a positive attitude towards bedsharing; item 3 is reversed. The components were structured as two subscales as the original scale indicated. The subscale of Positive Attitude Towards Solitary Sleeping and Positive Attitudes Towards Bedsharing were negatively correlated, r (1053) = .36, $p < .001$.

2.2.4. The Experiences in Close Relationship – Revised

The Experiences of Close Relationship Scale-Revised was used to measure the attachment insecurity of mothers in the current study. The scale was developed for the measurement of adult's romantic attachment characteristics by Fraley et al. (2000). The questions are arranged in the form of a 7-point Likert scale (1= almost never, 7= almost always). The scale has two dimensions: 18 items for attachment avoidance and 18 items for attachment anxiety. Although the scale has been commonly used to measure attachment-related anxiety and avoidance, it could also be used for categorizing an adult's attachment style considering the median scores of the dimensions. Test-retest reliability scores were .94 for the anxiety dimension, .95 for the avoidance dimension. Internal consistency Cronbach alpha value of anxiety dimension was .95, and internal consistency Cronbach alpha value of avoidance dimensions was .93 (Fraley et al., 2000).

The Turkish adaptation study was conducted by Selcuk et al. (2005). The Cronbach alpha coefficient was defined for the scale of the avoidance dimension as .90, while it was defined for the scale of the anxiety dimension as.86. Test-retest reliability scores were .82 for the anxiety dimension and .81 for the avoidance dimension (Selcuk et al., 2005).

Cronbach alpha value was .88 for the attachment anxiety dimension and .91 for the attachment avoidance dimension in this study.

2.2.5. The State-Trait Anxiety Inventory (STAI)

The State-Trait Anxiety Inventory (STAI) was used for the measurement of mothers' general anxiety levels in this study. The STAI was developed to measure state and trait anxiety by Spielberger, Gorsuch, and Lushene (1970). It has two questionnaire forms of 20 questions each. The questions are arranged in the form of a 4-point Likert scale (1= almost never, 4 = almost always). One of the forms is developed to measure state anxiety which figures out the person's anxiety of the current moment. The other form is developed to measure trait anxiety which figures out a person's general proneness to anxiety (Spielberger, 1983). The total scores are calculated, and the scores were placed between 20 and 80. STAI scores can indicate anxiety levels. The scores between 20-37 indicate low-level anxiety, the

scores between 38-44 indicate moderate level anxiety, and the scores between 45-80 indicate high-level anxiety (Kayikcioglu et al., 2017). In the original reliability and validity study, the state anxiety form's Cronbach's alpha values were ranged from .83 to .92. Trait anxiety form's Cronbach's alpha values were ranged from .86 to .92 (Spielberger, 1970). The adaptation of the STAI to Turkish was introduced by Öner and Le Compte (1985). Cronbach's alpha values ranged between .83 and .87 for the measure of trait anxiety; .94 and .96 for the measure of state anxiety (Öner & Le Compte, 1985).

Cronbach alpha value was .85 for the measure of trait anxiety and .93 for the measure of state anxiety in this study.

2.2.6. The Early Childhood Behaviour Questionnaire – Short Form

The Early Childhood Behavior Questionnaire (ECBQ: Putnam, Gartstein, & Rothbart, 2006) was used for the measurement of child temperament in this study. The ECBQ includes a 201-item questionnaire with 18 subscales measuring different dimensions of the temperament of young children. Dimensions are Activity Level, High-intensity Pleasure, Sociability, Positive Anticipation and Impulsivity, Discomfort, Fear, Motor Activation Sadness, Perceptual Sensitivity, Shyness, Soothability and Frustration, Inhibitory Control, Attention Shifting, Low-intensity Pleasure, Cuddliness, and Attention Focusing. The questions are arranged on a 7-point Likert scale (1= never, 2= very rarely to 7= always) for caregiver's self-report. N/A is the code when the situation of the question is not applicable for the child. (Putman et al., 2006). Reliability and validity of the ECBQ have been supported by samples from the United States (Putnam et al., 2006), and Russia (Kolmagorova et al., 2008), with mean alpha coefficients of .79, and.77, respectively. Activity Level, Fear, Frustration, Perceptual Sensitivity, and Soothability sub-scales from the ECBQ – Short Form will be used for this study. Cronbach alphas for these sub-scales for short-form were .75, .68, .73, .76, .73, respectively (Putnam & Rothbard, 2006).

The ECBQ was translated into Turkish by Acar & Ahmetoglu in 2017. Cronbach's alpha value was .79 for Activity Level, .81 for Fear, .92 for Frustration, .93 for Perceptual Sensitivity, and .76 for Soothability (Acar & Ahmetoglu, 2017).

Cronbach's alpha value was .62 for Activity Level, .72 for Fear, .80 for Frustration, .64 for Perceptual Sensitivity, and .80 for Soothability in this study.

2.3. PROCEDURE

Following the ethical approval for this study taken from the Istanbul Bilgi University Human Studies Ethics Board, the measures were administered to the participants on an online platform for data collection. All data were collected via the online survey tool, Google Forms. A survey link was made up, and the link was attached to the announcement of the study. The announcement included short information on the research subject and the participant criteria. The snowball sampling was used as a non-probability survey sampling method. The announcement with the link to the survey was distributed via WhatsApp groups, e-mail groups, and social media posts. Participants were asked to read the consent form when they opened the survey link. In the consent form, participants were informed that participating in the study is voluntary and can refuse to participate or withdraw freely, and the information about their identities was not received. After the participants' consent, the participants were asked to answer the questions on the demographic form and the measures. The participants filled the survey and scales, respectively: The Sleep Practices Questionnaire, The Parental Sleep Attitudes Scale, The Experiences in Close Relationship – Revised, The State-Trait Anxiety Inventory, The Early Childhood Behaviour Questionnaire - Short Form. It took about 25 minutes to answer all questions. The survey tool saved the completed forms.

2.4. DATA ANALYSIS

The data was transferred into Statistics 26.0 (Statistical Package for Social Sciences, version 26). All analysis was conducted using SPSS 26.0. Chi-Square tests were used for the frequency analyses of the sleep practices. Preliminary analyses were conducted to test the relationships between study variables and demographic/control variables. A series of between-subjects t-tests, a series of one-way between-subjects ANOVAs, and correlation analyses were used for preliminary analysis. Post-hoc comparisons with Bonferroni adjustment were conducted for the demographic/control variables with three or more categories. A

principal component analysis was conducted for the Parental Sleep Attitude Scale (PSAS) which was translated into Turkish for this study. Reliability analyses were conducted for the scales. Descriptive statistics of scale variables were conducted, including normality tests. Because the variables were not normally distributed, logarithmic transformation was used. Finally, a series of multivariate tests of covariance (MANCOVA) was conducted after the linearity, absence of multivariate outliers, absence of multicollinearity, homogeneity of variance, homogeneity of regression slopes, and the equality of covariance matrix was checked. As a follow-up to the MANCOVA, a series of one-way between-subjects ANOVAs and posthoc comparisons with Bonferroni adjustment were conducted for hypothesis testing. Later, the within-subjects t-tests were conducted for the maternal attitudes.

CHAPTER 3

RESULTS

Before reporting the results of the research questions for the current study, descriptive statistics of the study variables and the children's sleep habits, and the frequencies of the sleep practices according to demographic factors will be presented. First, the sleeping arrangements of children will be described, then the frequencies of children's sleep habits (e.g., sleep initiation styles, the frequencies of the night wakes of the children, mothers' responses tonight wakes, the age of beginning sleep through the night), mothers' perceptions of sleep problems, mothers' received criticism about the children's sleep arrangements will be presented. Following, the descriptive statistics of the scales will be presented. Finally, the results of the hypothesis testing will be reported.

3.1. DESCRIPTIVE STATISTICS OF THE SLEEP PRACTICES OF CHILDREN

3.1.1. Descriptive Statistics of the Children's Sleeping Arrangements

Sleeping Arrangement Classifications by Time

Children were classified into three sleep arrangement categories according to their sleep location's consistency and continuity. *Early co-sleeping children* were the children who have continuously and consistently slept with their parents (in the same room or the same bed) since birth or since any time in 0-12 months of age 5-7 nights a week. *Late-partial co-sleeping children* were the children who have begun sleeping with their parents (in the same room or in the same bed) after 12 months (late ones) or the children who have slept with their parents 3-4 nights a week (partial ones). *Solitary sleeping children* were the children who have slept most of the nights, 5-7 nights in a week separately.

The results showed that 56.3% of the children were *early co-sleeping* (N = 594), 12.5% of them were *late-partial co-sleeping* (N = 132), and 31.2% of the children were *solitary sleeping* (N = 329). Thus, the total co-sleeping rate was 68.8% for 18-48 months old children. See Table 3.1 for children's age distributions.

Maternal preferences for co-sleeping children's sleeping arrangements were as follows: 55.8% of the early co-sleeping children slept where their mothers prefer

the most, 23.2% slept where they do not prefer, 21% of the mothers of early co-sleeping children were not sure about their preferences of sleeping arrangements. For late-partial co-sleeping children, 35.5% of the late-partial co-sleeping children slept where their mothers prefer the most, 32.1% slept where they do not prefer, 32.8% of the mothers of late-partial co-sleeping children were not sure about their preferences of sleeping arrangements. For solitary sleeping children, 93.0% of the solitary sleeping children slept where their mothers prefer the most, 3% slept where they do not prefer, 4% of the mothers of solitary sleeping children were not sure about their preferences of sleeping arrangements (See Figure 3.1).

Table 3.1

Percentages of Children's Sleeping Arrangements According to the Beginning Time

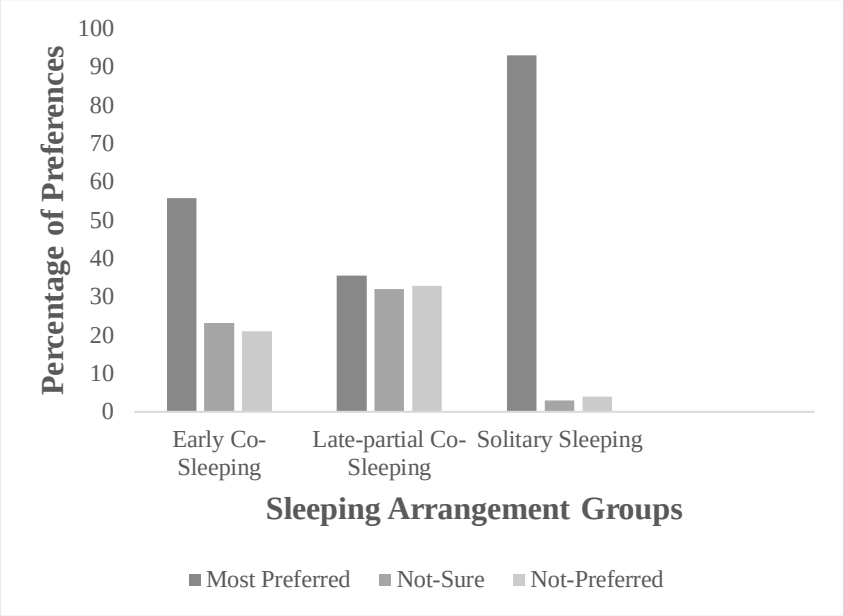
	Total (N = 1055)	18-24 months (N = 310)	24-36 months (N = 416)	36-48 months (N = 329)
	Percentage	Percentage	Percentage	Percentage
Early CS* (N = 594)	56.3	68.1	57.7	43.5
Late-partial CS (N = 132)	12.5**	8.7	9.9	19.5
Solitary sleeping (N = 329)	31.2	23.2	32.5	37.1

*CS: Co-sleeping

**.10 was the percentage of the late co-sleepers, and .2.5 was the percentage of the partial co-sleepers.

Figure 3.1

Mothers' Preferences of Their Children's Sleeping Arrangements by Sleeping Arrangements Groups



Sleeping Arrangement Classifications by Preferences

Co-sleeping children were classified into two categories according to the mothers' satisfaction and preference of sleeping arrangements. The mothers' preference was asked in "yes," "no," and "not sure" format. The mothers who answered "yes" and reported a satisfaction score of 3 and above, and the mothers who answered "not sure" and reported a satisfaction score of 4 and above were classified as "*intentional co-sleepers*," the mothers who answered "no" or "not sure" and reported a satisfaction score of 3 and below were classified as "*reactive co-sleepers*." Two participants had a disagreement between preference and satisfaction; they were excluded from the analyses.

The results showed that 39.8% of the children were intentional co-sleepers (N = 420), 29% of the children were reactive co-sleepers (N = 306), and 31.2% of the children were solitary sleepers (N = 329). See Table 3.2 for the distribution of the sleeping arrangements by the child's age.

Table 3.2

Percentages of Children's Sleeping Arrangements (Intentional / Reactive)

Sleep Arrangement	Total (N = 1055)	18-24 months (N = 310)	24-36 months (N = 416)	36-48 months (N = 329)
Intentional CS* (N = 420)	39.8	49.7	38.7	31.9
Reactive CS (N = 306)	29.0	27.1	28.8	31.0
Solitary sleeping (N = 329)	31.2	23.2	32.5	37.1

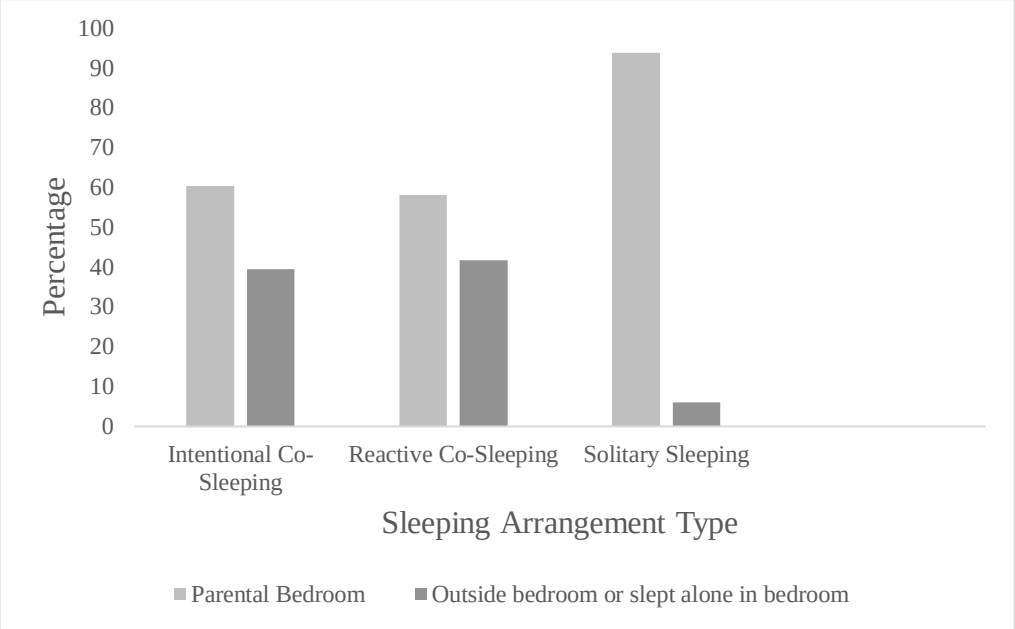
*CS: Co-sleeping

Sleep Locations of The Partners

Regarding the children's sleeping arrangements, 59.5% of partners of co-sleeping children's mothers (including all subtypes) slept in the parental bedroom (N = 432). In comparison, 40.5% of partners of co-sleeping children's mothers slept outside the bedroom or slept alone in the bedroom (N = 294). 93.9% of partners of solitary sleeping children's mothers slept in parental bedroom (N = 309) while 6.1% of the partners slept outside bedroom (N = 20), $X^2(1) = 128.29$, $p < .001$. Partner's sleep locations did not differ in intentional co-sleeping and reactive co-sleeping groups, $X^2(1) = 391$, $p = .53$, n.s. See Figure 3.2 for partner's locations by three categories of sleeping arrangements of children.

Figure 3.2

Frequencies (percentage) of Partners' Sleep Locations According to their Children's Sleeping Arrangements



3.1.2. Relationships Between Demographic Variables and Children's Sleeping Arrangements

A one-way between-subjects analysis of variance was conducted to compare the children's ages in different sleeping arrangement groups. The ANOVA indicated a children's ages had significantly different distributions between groups, $F(2, 1052) = 7.24$, $p = .001$. Post-hoc comparisons with Bonferroni adjustment showed that intentional co-sleeping group ($M = 29.13$, $SD = 8.89$) significantly younger than solitary sleeping group ($M = 31.78$, $SD = 8.89$), ($p = .001$) and reactive co-sleeping group ($M = 30.78$, $SD = 9.20$), ($p = .04$).

The Chi-square tests were conducted to examine the relationship between sleeping arrangement types (intentional, reactive, and solitary) and demographic and control variables (geographic region, gender of the child, number of children in the family, who looks after the child during working hours, being a preterm child, mild chronic illnesses in the child, mild chronic illnesses in the parents, mild psychiatric diagnosis, existence of past complications in the child, mothers' and

fathers' education level, work status, working hours, the family type, household income).

Household income was found to be related to sleeping arrangement type, and the solitary sleeping group was more likely to have a high level of income, $X^2(6) = 13.17$, $p < .05$. All groups most frequently had a monthly income above ৳9000.

The rate of going to school was higher for solitary sleeping children than co-sleeping children, $X^2(2) = 9.75$, $p < .05$.

3.1.3. The Frequencies of Sleep-Related Variables According to the Sleeping Arrangements

3.1.3.1. Demographic Variables and Sleep-Related Variables

The relationship between demographic or control variables and sleep-related behaviours was investigated for breastfeeding status, bedtime routines, perceptions of night-wake problems, and settling problems.

Children had a past complication (i.e., surgery, birth complication, icterus, etc.) were less likely to be breastfed, $X^2(2) = 5.22$, $p < .05$. Children who were only child were more likely to be breastfed, $X^2(1) = 27.21$, $p < .001$.

The higher education level of the mother was related to the higher frequency of reported bedtime routines. Mothers with graduate-level education reported that they practice bedtime routines more frequently than mothers with high-school or middle-school level education, $X^2(2) = 8.68$, $p < .05$. The higher education level of the fathers was related to the higher frequency of bedtime routine. According to the mothers' report, bedtime routine was less frequent in the children whose fathers with high-school, middle-school, or preschool level education than fathers had undergraduate or graduate-level education, $X^2(2) = 13.72$, $p < .001$. Children's bedtime routine was more frequent in families with higher income levels, $X^2(3) = 21$, $p < .001$. The bedtime routines were more frequent in the children who had no siblings, $X^2(1) = 11.29$, $p < .001$.

Mothers who reported ৳6000-9000 of monthly household income reported a higher level of the perceived night-wakes problem more frequently than mothers who reported above ৳9000 monthly household income, $X^2(6) = 15.70$, $p < .05$.

Mothers who had an only child were more likely to report a higher level of perceived settling problems, $X^2(2) = 13.07$, $p < .001$.

The results showed that 34% of children who had a room were intentional co-sleepers, %27.1% of them were reactive co-sleepers. Regarding the children's sleeping arrangements, 64.4% of children who did not have a room were intentional co-sleepers, 37.7% of them were reactive co-sleepers.

Regarding the income levels, 28% of the children who did not have a room had a monthly household income under ৳6000. (These children were 5.4% of all samples). 28% of the children without a room had a monthly household income between ৳6000-9000, and 43.1% of their income was about ৳9000.

16.9% of the children who had a room had a monthly income under ৳6000 (These children were 13.6% of all sample), 23.1% had a monthly income between ৳6000-9000, and 60% of them had a monthly income above ৳9000. Both the groups of having a room or not having a room were more likely to have a high income, $X^2(2) = 21.42$, $p < .001$

3.1.3.2. The Frequencies of Sleep-Related Variables

Breastfeeding – Night Feeding Status of the Children

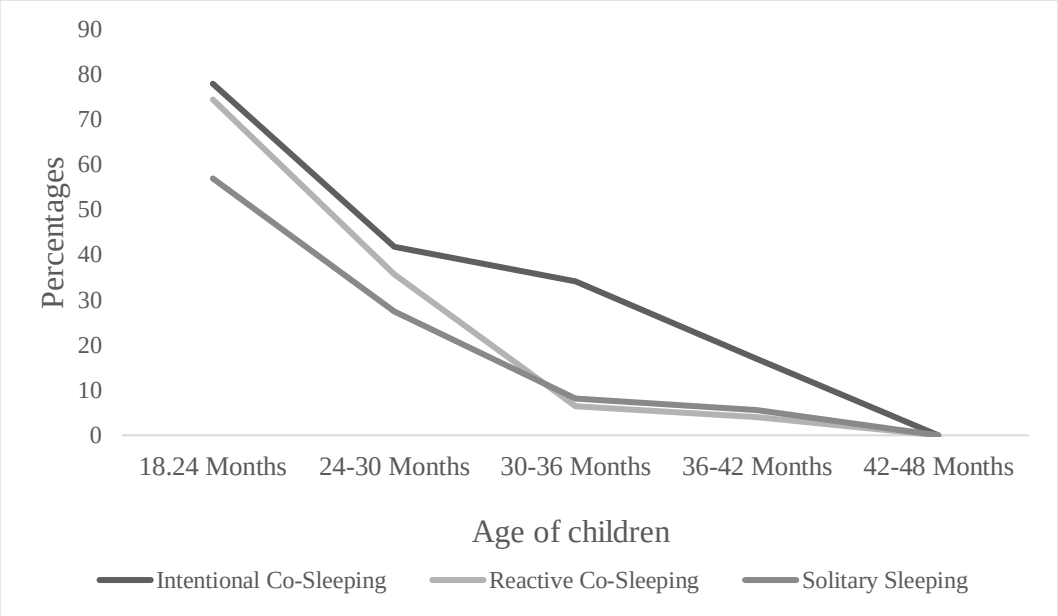
In total, 34.4% of children were breastfed or continued night feeding (N =363). Regarding age groups, 72.9% of 18-24 months old children, 35.1% of 24-30 months old children, 18.8% of 30-36 months old children, 8.7% of 36-42 months old children, 4.5% of 42-48 months old children were breastfed or continued night feeding. The breastfeeding or night-feeding percentage in the intentional co-sleeping group was 46.9%, it was 31.4% for the reactive co-sleeping group, and 21.3% for the solitary sleeping group.

The Chi-square tests were conducted with adjusted p-values with the Bonferroni method for different age groups. For 18-24 months old children, the solitary sleeping group had a lower frequency rate of breastfeeding than the intentional co-sleeping, and reactive co-sleeping group had, $X^2(2) = 12.09$, $p < .01$. The breastfeeding/night-feeding percentage was 77.9% for the intentional co-sleeping group, 77.4% for the reactive co-sleeping group, and 56.9% for the solitary sleeping group at 18-24 months. For 24-36 months old children, intentional co-

sleeping children had a higher frequency rate of breastfeeding than reactive co-sleeping children and solitary sleeping children, $X^2(2) = 14.79$, $p < .01$. The breastfeeding/night-feeding percentage was 37.9 for intentional co-sleeping children, 24.2% for reactive co-sleeping children, and 18.5% for solitary sleeping children at 24-36 months. For 36-48 months old children, intentional co-sleeping children had a higher frequency rate of breastfeeding than reactive co-sleeping children and solitary sleeping children, $X^2(2) = 18.23$, $p < .001$. The breastfeeding/night-feeding percentage was 15.2 for intentional co-sleeping children, 2% for reactive co-sleeping children, and 3.3% for solitary sleeping children at 36-48 months. See Figure 3.3 for the age-by-age distribution of breastfeeding and night feeding status by sleeping arrangements.

Figure 3.3

Percentages of Breastfeeding and Night Feeding by Age in Different Sleeping Arrangement Groups.



The Sleep Initiation Styles of The Children

The frequencies of the children's sleep initiation methods were examined by multiple-choice questions. According to maternal reports, in total, 25.7% of the

children fell asleep by nursing (N = 271), 22.4% of the children fell sleep by bedsharing with their parents (cuddling, only lying, or listening books, fairy tales) (N = 236), 15.8% of the children fell asleep by bedsharing accompanied by touching and playing their mothers' hair, arm, ear, etc. (N = 167), 8.2% of the children fell asleep by rocking (N = 87), 6.5% of the children fell asleep by parental presence but without bedsharing (N = 69), 6.4% of the children fell asleep by themselves or using a sleep aid (N = 67), 5.8% of the children slept with a pacifier and parental presence (lying together or rocking) (N = 61), 4.5% of children fell asleep by bottle feeding (N = 48), 2.1% of the children fell asleep by holding (N = 22), 1.6% of the children fell asleep using a pacifier without parental presence (N = 17), 0.7% of the children fell asleep by watching screen (N = 7), 0.3% of the children fell asleep by moving around on the lap or in a car (N =3).

As a sleep initiation method, nursing was more frequent in intentional co-sleeping children than reactive co-sleeping and solitary sleeping children ($p < .001$). Nursing was less frequent in solitary sleeping children than intentional and reactive co-sleeping children ($p <. 001$). Parental presence without bedsharing was more frequent in solitary sleeping children than co-sleeping children ($p <. 001$). Playing with the mother's arm, hair, etc., during bedsharing was more frequent in reactive co-sleeping children than intentional co-sleeping children and solitary sleeping children ($p <. 001$). The frequency of bedsharing without playing with the mother did not differ between sleeping arrangement groups. Sleeping alone in a bed/crib and using a pacifier was more frequent in solitary sleeping children than co-sleeping children ($p <. 001$). See Table 3.3 and Table 3.4 for the distribution by age groups and the sleeping arrangements.

The results showed that 35.5% of children had a transitional object currently or in the past. The percentage was 40.4% for 36-48 months old children. 45% of solitary sleeping children had a transitional object (regardless of sleep time or daytime) in the past or at the data collection period of current research, while 31% intentional co-sleeping children, and 30.7% of reactive co-sleeping children had. Solitary sleeping children were more likely to have a transitional object, $X^2(4) = 23.98$, $p < .001$.

Table 3.3

Frequencies of The Sleep Initiation Methods by Age

Sleep Initiation Style		Age (Months)				
	Total	18-24 (*N*=310)	24-30 (*N* =225)	30-36 (*N*=191)	36-42 (*N*=173)	42-48 (*N*=156)
Nursing	25.7	54.2	28.4	13.6	4.6	3.2
Rocking	8.2	8.4	9.8	9.4	8.1	4.5
Bottle Feeding	4.5	3.5	8.0	6.3	1.7	2.6
Bedsharing (cuddling, or listening fairy tales)	22.4	7.4	17.3	24.1	37.0	41.0
Bedsharing (playing their mothers' hair, arm, ear etc.)	15.8	5.5	12.9	23.0	22.0	25.0
Parental presence without bedsharing (listening songs, fairy tales, or touching)	6.5	1.9	5.8	9.9	8.7	10.3
Holding	2.1	2.3	4.0	0.5	1.7	1.3
In a bed/crib alone	6.4	2.6	5.8	6.3	11.6	9.0
Using a pacifier with parental presence (bedsharing or rocking)	5.8	11.0	4.4	4.7	3.5	1.3
Using a pacifier without parental presence	1.6	2.9	1.8	1.0	0.0	1.3
Watching (screen)	0.7	0.0	1.3	0.5	1.2	0.6
Moving around on the lap or in a car	0.3	0.3	0.4	0.5	0.0	0.0

Table 3.4

Frequencies of The Sleep Initiation Methods by Sleeping Arrangements

Sleep Initiation Style	Sleeping Arrangement			
	Intentional Co-Sleeping (*N* = 420)	Reactive Co-Sleeping (*N* = 306)	Solitary Sleeping (*N* = 329)	*p*
Nursing	36.9a	25.2b	11.9c	
Rocking	6.9a	9.8a	8.5a	
Bottle Feeding	3.8a	5.9a	4.3a	
Bedsharing (cuddling, or listening fairy tales)	22.1a	21.9a	23.1a	
Bedsharing (playing their mothers' hair, arm, ear etc.)	13.6a	20.3b	14.6a,b	
Parental presence without bedsharing (listening songs, fairy tales, or touching)	4.5a	4.2a	11.2b	0.001***
Holding	2.9a	2.3a	0.9a	
In a bed/crib alone	2.6a	3.6a	13.7b	
Using a pacifier with parental presence (bedsharing or rocking)	5.7a	5.6a	6.1a	
Using a pacifier without parental presence	0.0a	0.3a	4.9b	
Watching (screen)	0.7a	0.3a	0.9a	
Moving around on the lap or in a car	0.2a	0.7a	0.0a	

A column with single different letters was significantly different (chi-square post hoc analysis with adjusted p values)

****p*<.001

The Mothers' Responses to the Night Wakes of Their Children

Maternal responses when the children wake at night were investigated by the questionnaire. The frequency of each response (the maternal behaviour as a response to the children's night wakes such as nursing, taking the child the parental bed, etc.) was asked on a 5-point Likert scale (1: I never do this; 3: I sometimes do this; 5: I always do this). The mothers who scored 3 to 5 (sometimes to always) for a response were included in the frequency table as the mothers who responded the child's night wakes with the described behaviour. The age-dependent frequencies of mothers' responses are presented in Table 3.5.

The frequency of the mothers' responses to night wakes of their children differed between sleeping arrangement types. Nursing had a higher frequency in intentional co-sleeping groups than reactive co-sleeping and solitary sleeping groups. The reactive co-sleeping group also had a higher frequency of nursing response than the solitary sleeping group ($p < .001$). Feeding was more frequent in the intentional co-sleeping group than reactive co-sleeping and solitary sleeping group ($p < .01$). Holding was less seen in the solitary sleeping group than intentional co-sleeping and reactive co-sleeping group ($p < .01$). Giving an object and talking responses were more frequent in the solitary sleeping group than other sleeping arrangement groups ($p < .01$). Taking to the parental bed, the child was more frequent in reactive co-sleeping group than other sleeping arrangement groups, and it was also more frequent in the intentional co-sleeping group than solitary sleeping group ($p < .001$). Responses of no interaction and taking back the child to his/her bed when the child comes parental bed were more frequent in the solitary sleeping group than other sleeping arrangement groups. These responses were also more frequent in the reactive co-sleeping group than intentional co-sleeping groups ($p < .001$). See Table 3.6 for the distribution by sleeping arrangement/age groups.

Table 3.5

Frequencies of Mothers' Responses to Children's Night Wakes by Age

Mothers' Reponses to Night-Wakes (mothers sometimes to always do)	Total	18-24 months (*N* = 310)	24-30 months (*N* =225)	30-36 months (*N* = 191)	36-42 months (*N*= 173)	42-48 months (*N* = 156)
Nursing	29.1	57.8	29.3	16.8	9.2	7.1
Feeding	14.1	23.9	14.7	11.5	6.9	5.1
Holding	71.5	74.5	74.2	68.6	72.3	64.1
Giving an object	24.3	20.3	26.7	24.1	27.2	25.6
Giving a pacifier	11.2	19.4	13.3	7.3	4.6	3.8
Talking	31.3	26.5	32.0	36.1	31.2	34.0
Taking to parental bed	52.7	52.9	51.6	57.1	54.3	46.8
Co-Sleeping in the child's bed	38.0	31.0	34.2	40.8	48.0	42.9
No interaction	39.1	34.2	33.3	40.8	46.8	46.8
The child comes to parental bedroom and the parents takes him/her back	8.8	2.9	6.7	9.4	14.5	16.7
The child comes to parental bedroom and the parents says her/him to go	4.5	1.6	4.4	4.7	6.9	7.7

Table 3.6

Frequencies of Mothers' Responses to Night Wakes by Sleeping Arrangements

Mothers' Reponses to Night-Wakes (mothers sometimes to always do)	Intentional Co-Sleeping (N = 420)	Reactive Co-Sleeping (N = 306)	Solitary Sleeping (N =329)	X^2
Nursing	41a	29.7b	13.4c	69***
Feeding	16.7a	15.7a,b	9.4b	9**
Holding	73.6a	74.5a	66.0b	7**
Giving an object	21.2a	21.6a	30.7b	11**
Giving a pacifier	9.5a	11.4a	13.1a	2
Talking	26.2a	27.1a	41.6b	24***
Taking to parental bed	58.6a	74.5b	24.9c	166***
Co-Sleeping in the child's bed	37.6a	34.6a	41.6a	3
No interaction	28.6a	40.2b	51.7c	42***
The child comes to parental bedroom and the parents takes him/her back	2.4a	7.2b	18.5c	61***
The child comes to parental bedroom and the parents says her/him to go	1.9a	5.9b	6.7b	11**

Column with single different letters was significantly different (chi-square post hoc analysis with adjusted p values)

*** $p < .001$, ** $p < .01$

Sleep Training and Sleeping Arrangements

In total, 14.5% of the children had sleep training (*N* = 153). 26.8% of sleep-trained children were intentional co-sleepers (*N*=41), 23.5% of sleep-trained children were reactive co-sleepers (*N* = 36), and 49.7% of them were solitary sleepers (*N* = 76).

Sleep Through the Night

The results were as follows: 13.6% of the children began to sleep through the night at 6-12 months, 12.3% of them began to sleep through the night at 12-18 months, 12.5% of them began to sleep through the night at 18-24 months, 25.3% of them began to sleep through the night after 24 months, and 36.3% of children waked at nights. The beginning ages of sleep through the night in different sleeping arrangement groups are presented in Table 3.7. The age of beginning sleep through the night and the weaning age had a moderate correlation, *rs* = .33.

The results indicated that 57.1% of 18-24 months old children, 35.6% of 24-36 months old children, and 17.6% of 36-48 months old children waked at night.

Night Wake Durations of Children

Most children's night wake durations were in the normal range 90.4% of the children's (*N* = 954) night wake duration was 1-15 minutes, 5% of 15-30 minutes (*N* = 53), and 4.5% was above 30 minutes (*N* = 48).

Table 3.7

Percentage of The Age of Beginning Sleep Through the Night According to Sleeping Arrangements

	The Age of Beginning Sleep Through the Night				
Sleeping Arrangement Type	At 6-12 Months (N = 143)	At 12-18 months (N = 130)	At 18-24 months (N = 132)	After 2 years old (N = 267)	Wakes at nights (N = 383)
Intentional CS*	11.4	11.0	12.4	23.4	41.9
Reactive CS	11.1	8.8	11.1	22.2	46.7
Solitary Sleeping	18.5	17.3	14.0	30.7	19.5

*CS: Co-sleeping

The Bedtime Routines and Sleeping Arrangements

According to the results, 54.6% of intentional co-sleeping children, 54.2% of reactive co-sleeping children, and 65% of solitary sleeping children often had or always had a bedtime routine, $X^2(2) = 8.83$, $p < .05$. For 18-24 months old children, reactive co-sleeping children's mothers reported that they practice a bedtime routine less frequently than other mothers, $X^2(2) = 9.84$, $p < .01$,

Mothers' Perceptions of Night-Waking Problems of The Children

Mothers of reactive co-sleeping children were more likely to had perceived night-wakes problems in their children, while mothers of solitary sleeping children were less likely to had perceived night-wakes problems ($p < .001$). (See Table 3.8).

Table 3.8

Percentages of Mothers' Perceived Night-Wakes Problems in the Children According to Sleeping Arrangements

	The Level of Mothers' Perceptions of Night-Wakes Problems			
Sleeping Arrangement Type	Low level (percentage)	Moderate level (percentage)	High level (percentage)	X^2
Intentional CS	51.4a	21.0a	27.6a	
Reactive CS	31.4a	16.0a	52.6b	108***
Solitary Sleeping	65.0a	18.5b	16.4c	
Total	49.9	18.8	31.4	

***p < .001

Mothers' Perceptions of Settling Problems of the Children

Mothers of reactive co-sleeping children were more likely to had perceived settling problems in their children, while mothers of solitary sleeping children were less likely to had perceived settling problems (p < .001). (See Table 3.9)

Table 3.9

Percentages of Mothers' Perceived Settling Problems in the Children According to Sleeping Arrangements

	The Level of Mothers' Perceptions of Settling Problems			
Sleeping Arrangement Type	Low level (percentage)	Moderate level (percentage)	High level (percentage)	X^2
Intentional CS	34.8a	31.0a	34.3a	
Reactive CS	18.6a	24.2b	57.2c	91***
Solitary Sleeping	48.0a	28.0b	24.0c	
Total	34.2	28.1	37.7	

****p* < .001

Mothers' Perceived Criticism about the Child's Sleeping Arrangements

The results indicated that 64.5% of mothers of intentional co-sleeping children reported that they did not feel criticized, 18.6% of them reported that they feel somewhat criticized, and 19.9% of them reported that they feel quietly criticized about their children's sleeping arrangements.

When the perceived criticism was examined in different sleeping arrangement groups, 50.3% of mothers of reactive co-sleeping children reported that they did not receive criticism, 21.2% reported that they felt somewhat criticized, and 28.4% reported that they felt quietly criticized about their children's sleeping arrangements. 91.2% of mothers of solitary sleeping children reported that they did not receive criticism, 3.6% reported that they felt somewhat criticized, and 5.2% reported that they felt quietly criticized about their children's sleeping arrangements. (See Table 3.10)

Table 3.10

Percentages of Mothers' Perceived Criticism about the Child's Sleeping Arrangements

	The Level of Mothers' Perceived Criticism			
Sleeping Arrangement Type	Low level (percentage)	Moderate level (percentage)	High level (percentage)	X^2
Intentional CS	64.5	18.6	19.9	
Reactive CS	50.3	21.2	28.4	133***
Solitary Sleeping	91.2	3.6	5.2	

***$p < .001$

3.2. HYPOTHESIS TESTING

A series of one-way multiple analysis of variance was conducted to examine differences in attitudes towards sleeping arrangements; mothers' attachment insecurity, mothers' anxiety level, and children's temperamental characteristics of fear, activity level, perceptual sensitivity, frustration, and soothability between sleeping arrangement groups of intentional co-sleeping, reactive co-sleeping, and solitary sleeping.

First, the assumptions were checked. Normality tests with the Shapiro-Wilk test indicated that the study variables were not normally distributed in the data. The Trait Anxiety, State Anxiety, Attachment Anxiety, and Attachment Avoidance scores were positively skewed as expected from a non-clinical population. The temperament subscales changed in terms of the direction of the tail. Activity Level, Perceptual Sensitivity, and Soothability were negatively skewed, while Fear and Frustration were positively skewed. Attitudes Towards Bedsharing and The Attitudes Towards Solitary Sleeping scores were negatively skewed. The *F* Test is robust to normality assumption unless the violations are not severe (Keppel. 1982, pp.145). Normality tests could not be reliable in large sample sizes, and the eyeball test is recommended for normality checks (Kim, 2013). The skewness and kurtosis scores were between -1 and +1 for all study variables for the data, and between -1.5 and +1.5 for all conditions, as Tabachnick and Fidel (2013) described as not severe. Logarithmic transformations were applied to scale variables to close normal distribution and satisfy the assumptions of the multivariate analyses. The linearity, absence of multivariate outliers, absence of multicollinearity, and the equality of covariance matrix were checked. 10 outliers were excluded using boxplots to attain linearity, and 4 outliers were excluded using Mahalanobis' distance.

The descriptive statistics of the study variables, the relationships between study variables, and the relationships between demographic variables and study variables were investigated below.

3.2.1. Descriptive Statistics of The Scales

Means, standard deviations, minimum and maximum scores of all scale variables after 14 outliers were extracted for hypotheses testing are presented in Table 3.11.

Table 3.11

Descriptive Statistics of the Scales of Study Variables

Scale	*Min*	*Max*	*M*	*SD*	*N*
The Parental Sleep Attitude Scale (PSAS)					
Attitudes Towards Bedsharing	2.00	6.00	4.91	0.99	1041
Attitudes Towards Solitary Sleeping	1.00	6.00	4.30	1.19	1041
The Experiences in Close Relationships – Revised (ECR-R)					
Attachment Anxiety	1.00	6.67	2.89	0.96	1041
Attachment Avoidance	1.00	6.72	2.29	0.98	1041
The State – Trait Anxiety Inventory (STAI)					
State Anxiety	20.00	76.00	33.60	10.72	1041
Trait Anxiety	22.00	76.00	43.52	9.14	1041
The Early Childhood Behaviour Questionnaire – Short Form					
Activity Level	1.88	7.00	5.17	0.83	1041
Fear	1.00	6.50	2.75	0.98	1041
Frustration	1.17	6.67	3.70	1.08	1041
Perceptual Sensitivity	1.40	7.00	5.86	0.89	1041
Soothability	1.40	7.00	5.00	1.01	1041

3.2.2. Preliminary Analyses

A series of the between-subjects *t*-test, a series of the one-way analysis of variances (ANOVA) for categorical demographic variables that have applicable group sample sizes (gender of the child, work status of mothers, working hours of mothers), the Pearson's correlation analyses for the scale variables, and the Spearmen's correlation analyses for mothers' and children's age, household income level, and the education level of the parents were conducted. The Pearson's correlations between scale variables are presented in Table 3.12.

Some temperament scores were correlated with children's age. Soothability was negatively correlated with children's age, $rs = -.20$, $p < .01$. Fear was correlated with children's age, $rs = .15$, $p < .01$. Frustration was correlated with children's age, $rs = .10$, $p < .01$.

Attachment anxiety, attachment avoidance, and trait anxiety was negatively correlated with income level, correlation coefficients of $rs = -.09$, $rs = --.06$, and $rs = -.10$, respectively, ($p < .01$).

Fear scores were significantly higher in girls than boys ($p = .006$). Activity Level scores were significantly higher in boys than girls ($p = .012$).

Soothability scores were lower for the children whose mothers worked full time or than the children whose mothers worked part-time or flexible ($p = .004$). Activity level scores were higher for the children whose mothers worked full time than the children whose mothers did not work ($p = .008$).

Breastfeeding status was related to attitudes towards bedsharing, solitary sleeping, soothability, frustration, and fear ($p < .001$). Children who were breastfed currently had higher soothability scores and lower frustration and fear scores than children who were not breastfed currently ($p < .001$). Maternal attitudes towards solitary sleeping scores were lower, while maternal attitudes towards bedsharing scores were higher for breastfeeding mothers ($p < .001$).

Table 3.12

Correlations for Scale Variables

Variable	1	2	3	4	5	6	7	8	9	10	11
1. Attitude Towards Bedsharing											
2. Attitude Towards Solitary Sleeping	-.37**										
3. Attachment Anxiety	.00	-.14**									
4. Attachment Avoidance	-.05	-.06*	.55**								
5. State Anxiety	.01	-.08*	.42**	.41**							
6. Trait Anxiety	.03	-.08**	.59**	.47**	.66**						
7. Activity Level	.05	.08**	-.09**	.01	-.01	-.06					
8. Fear	.01	.01	.25**	.19**	.18**	.24**	-.01				
9. Frustration	.01	-.10**	.33**	.22**	.28**	.36**	.28**	.38**			
10. Perceptual Sensitivity	. 06	. 05	.02	-.13**	-.08**	-.03	.18**	.07	.01		
11. Soothability	.02	-.07*	-.26**	-.21**	-.24**	-.28**	-.20**	-.30**	-.55**	.11**	

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

3.2.3. The Relationships Between Sleeping Arrangements and Study Variables

A one-way multivariate analysis of covariance (MANCOVA) was conducted to examine the differences in maternal attitudes towards bedsharing, maternal attitudes toward solitary sleeping; mothers' trait anxiety scores, mothers' state anxiety scores, mothers' attachment avoidance scores, mothers attachment anxiety scores, and scores on children's temperamental characteristics of activity level, fear, frustration, perceptual sensitivity, and soothability between sleeping arrangement groups of intentional co-sleeping, reactive co-sleeping, and solitary sleeping, age was controlled. The assumption of homogeneity of regression slopes were satisfied. Box's *M* value was 158.05, $p = .078$. Significant differences were found among the three groups on the dependent measures, F (22, 2054) = 11.87, $p < .001$, Wilk's $\Lambda = .79$, $\eta_p^2 = .11$.

Prior to conducting a series of follow-up ANOVAs, the homogeneity of variance was checked for all subscales. Levene's *F* test was not significant except for two subscales. Although the Levene's *F* test suggested that the variances associated with The State Anxiety and The Attitudes Towards Solitary Sleeping subscales were not homogenous, the ratios of standard deviations were less than 1.5, suggesting that the ANOVA would be robust in these cases (Howell, 2011). As Allen and Bennett (2008) suggested, .001 was used as an alpha level for these cases.

A series of one-way ANOVA's on dependent variables was conducted as the follow-up tests to the MANOVA. All the ANOVA's were significant except Perceptual Sensitivity, with effect sizes (η_p^2) from .009 to .132. (See Table 3.13)

Table 3.13

Univariate Tests of Between Subject *Effects, Controlled for Age*

Variable	*df*	*F*	*p*	η_p^2
Attitude Towards Bedsharing	2	45.43	<.001	.081
Attitude Towards Solitary Sleeping	2	79.17	<.001	.132
State Anxiety	2	15.11	<.001	.028
Trait Anxiety	2	15.38	<.001	.029
Attachment Anxiety	2	6.85	.001	.013
Attachment Avoidance	2	10.32	<.001	.020
Activity Level	2	5.19	.006	.010
Fear	2	7.54	.001	.014
Frustration	2	14.82	<.001	.028
Perceptual Sensitivity	2	1.15	.317	.002
Soothability	2	4.87	.008	.009

A one-way multivariate analysis of covariance (MANCOVA) was conducted, including demographic covariates (gender, children's age, mothers' working hours, income level). The assumption of homogeneity of regression slopes was satisfied. Box's *M* value was 158.64, $p = .073$. Significant differences were found between the three groups on the dependent measures, F (22, 2046) = 11.9, $p < .001$, Wilk's $\Lambda = .81$, $\eta_p^2 = .11$, controlled for children's age, gender, income level.

Before conducting a series of follow-up ANOVAs, the homogeneity of variance was checked for all subscales. Levene's *F* test was not significant except for attitudes towards solitary sleeping. Although the Levene's *F* test suggested that the variances associated with The Attitudes Towards Solitary Sleeping subscale were not homogenous, the ratios of standard deviations were less than 1.5, suggesting that the ANOVA would be robust in this case (Howell, 2011), and an alpha level of .001 was used for this case. A series of one-way ANOVA's on dependent variables was conducted as the follow-up tests to the MANOVA. All the

ANOVA's were significant except perceptual sensitivity, with effect sizes (η_p^2) from .008 to .135. (See Table 3.14)

Table 3.14

Univariate Tests of Between Subject Effects, Controlled for Age, Gender, Working Hours, and Income Level

Variable	*df*	*F*	*p*	η_p^2
Attitude Towards Bedsharing	2	45.95	<.001	.082
Attitude Towards Solitary Sleeping	2	80.51	<.001	.135
State Anxiety	2	14.69	<.001	.028
Trait Anxiety	2	13.78	<.001	.026
Attachment Anxiety	2	6.51	.002	.012
Attachment Avoidance	2	9.15	<.001	.017
Activity Level	2	5.14	.005	.010
Fear	2	7.71	<.001	.015
Frustration	2	14.49	<.001	.027
Perceptual Sensitivity	2	1.16	.293	.002
Soothability	2	4.22	.015	.008

Lastly, a one-way multivariate analysis of covariance (MANCOVA) was conducted, all covariates, including breastfeeding status was controlled. Box's *M* value was 158.64, $p = .078$. Significant differences were found between the three groups on the dependent measures, F (22, 2042) = 10.46, $p < .001$, Wilk's $\Lambda = .81$, $\eta_p^2 = .10$, controlled for children's age, gender, income level, and breastfeeding status.

Levene's *F* test suggested that the variances associated with The Attitudes Towards Solitary Sleeping subscale were not homogenous. The ratios of standard deviations were less than 1.5, suggesting that the ANOVA would be robust in this case (Howell, 2011), then .001 was used as an alpha level for this case. A series of one-way ANOVA's on dependent variables was conducted as the follow-up tests

to the MANOVA. All the ANOVA's were significant except perceptual sensitivity, with effect sizes (η_p^2) from .008 to .115. (See Table 3.15).

Table 3.15

Univariate Tests of Between Subject Effects, Controlled for Age, Gender, Working Hours, Income Level, and Breastfeeding Status

Variable	*df*	*F*	*p*	η_p^2
Attitude Towards Bedsharing	2	36.64	<.001	.066
Attitude Towards Solitary Sleeping	2	67.21	<.001	.115
State Anxiety	2	14.59	<.001	.028
Trait Anxiety	2	13.74	<.001	.026
Attachment Anxiety	2	6.50	.002	.012
Attachment Avoidance	2	9.30	<.001	.018
Activity Level	2	5.32	.005	.010
Fear	2	7.85	<.001	.015
Frustration	2	13.91	<.001	.026
Perceptual Sensitivity	2	1.23	.293	.002
Soothability	2	4.21	.015	.008

Pairwise comparisons using estimated marginal means (controlled for children's age, gender, mothers' working hours, income level, and breastfeeding status) were conducted with Bonferroni correction. Alpha level of .001 was used for the pairwise comparisons of the attitudes towards bedsharing. Post-hoc tests indicated that mothers of intentional co-sleeping children had a significantly more favourable attitude towards bedsharing than mothers of reactive co-sleeping children and mothers of solitary sleeping children (p <. 001). Mothers of intentional co-sleeping children had significantly less favourable attitudes towards solitary sleeping than mothers of reactive co-sleeping children and mothers of solitary sleeping children (p < .001).

Mothers of reactive co-sleeping children had a higher level of trait anxiety than mothers of intentional co-sleeping children and mothers solitary sleeping children ($p < .001$). Mothers of reactive co-sleeping children had a higher level of state anxiety than mothers of intentional co-sleeping children and mothers of solitary sleeping children ($p < .001$).

Mothers of reactive co-sleeping children had higher attachment anxiety scores than mothers of intentional co-sleeping children ($p = .02$), and they had higher attachment anxiety scores than the mothers of solitary sleeping children ($p = .002$). Mothers of reactive co-sleeping children had higher attachment avoidance scores than mothers of intentional co-sleeping children ($p = .03$), and they had higher attachment avoidance scores than mothers of solitary sleeping children ($p < .001$).

Reactive co-sleeping children had higher scores on activity level than solitary sleeping children had ($p = .005$). Reactive co-sleeping children had higher scores on fear than intentional co-sleeping children ($p = .012$) and solitary sleeping children ($p = .001$). Reactive co-sleeping children had higher scores on frustration than intentional co-sleeping children and solitary sleeping children ($p < .001$). Reactive co-sleeping children had lower scores on soothability than solitary sleeping children ($p = .02$). The estimated marginal means for each group with back-transformed values are presented in Table 3.16.

The raw mean values and the standard deviations were for each were presented for each group in Table 3.17-3.19.

Table 3.16

Estimated Marginal Means and Pairwise Comparisons

	Intentional Co-Sleeping (*N* = 414)		Reactive Co-Sleeping (*N* =303)		Solitary Sleeping (*N* = 322)		*P*	Pairwise Comparisons
	EMM	CI95%	EMM	CI95%	EMM	CI95%		
Attitudes Towards Bedsharing	5.38	5.31 – 5.45	5.02	4.92 - 5.12	4.86	4.75 – 4.96	<.001	intentional > reactive, solitary
Attitudes Towards Solitary Sleeping	4.06	4.18 – 3.94	4.75	4.64 – 4.86	4.93	4.83 – 5.02	<.001	intentional < reactive, solitary
State Anxiety	31.48	30.55 – 32.36	34.59	33.42 – 35.81	30.62	29.65 – 31.62	<.001	reactive > intentional, solitary
Trait Anxiety	41.98	41.11 – 42.85	44.88	43.75 – 45.92	41.30	40.36 – 42.27	<.001	reactive > intentional, solitary
Attachment Anxiety	2.70	2.62 – 2.79	2.90	2.79 – 3.00	2.64	2.55 – 2.74	.002, .02	reactive > intentional, solitary
Attachment Avoidance	2.08	2.00 – 2.17	2.26	2.16 – 2.37	1.96	1.87 – 2.05	<.001, .03	reactive > intentional, solitary
Activity Level	5.29	5.21 – 5.37	5.42	5.33- 5.51	5.20	5.10 – 5.29	.005	reactive > solitary
Fear	2.55	2.47 – 2.64	2.74	2.64 – 2.86	2.47	2.37 – 2.56	.012 .001	reactive > intentional, solitary
Frustration	3.43	3.33 – 3.53	3.82	3.69 – 3.95	3.41	3.30 – 3.52	<.001	reactive > intentional, solitary
Soothability	5.21	5.11- 5.30	5.04	4.92 – 5.14	5.24	5.14 – 5.35	.02	reactive < solitary

Table 3.17

Mean Values of Maternal Attitudes in Sleeping Arrangement Groups (Raw Data)

	Intentional Co-Sleeping (*N* = 414)		Reactive Co-Sleeping (*N* =303)		Solitary Sleeping (*N* = 322)	
	M	SD	M	SD	M	SD
Attitudes Towards Bedsharing	5.23	0.85	4.81	0.98	4.59	1.06
Attitudes Towards Solitary Sleeping	3.76	1.24	4.60	0.89	4.71	1.11

Table 3.18

Mean Values of Maternal Anxiety and Attachment Insecurity in Sleeping Arrangement Groups (Raw Data)

	Intentional Co-Sleeping (*N* = 414)		Reactive Co-Sleeping (*N* =303)		Solitary Sleeping (*N* = 322)	
	M	SD	M	SD	M	SD
Trait Anxiety	42.88	8.66	45.93	9.52	42.08	8.87
State Anxiety	32.86	9.97	36.42	11.72	31.95	10.16
Attachment Anxiety	2.86	0.94	3.08	1.04	2.77	0.88
Attachment Avoidance	2.25	0.94	2.49	1.04	2.15	0.95

Table 3.19

Mean Values of Children's Temperament Scores in Sleeping Arrangement Groups (Raw Data)

	Intentional Co-Sleeping (*N* = 414)		Reactive Co-Sleeping (*N* =303)		Solitary Sleeping (*N* = 322)	
	M	SD	M	SD	M	SD
Activity Level	5.16	0.82	5.30	0.79	5.06	0.88
Fear	2.69	0.96	2.93	1.00	2.65	0.95
Frustration	3.55	1.06	3.99	1.09	3.61	1.05
Perceptual Sensitivity	5.85	0.84	5.92	0.89	5.82	0.96
Soothability	5.07	1.00	4.84	1.03	5.05	0.96

3.2.4. Additional Analyses

3.2.4.1. Within-Group Differences in Maternal Attitudes of Sleeping Arrangements

Three correlated-samples t-tests were conducted to examine within-group differences of maternal attitudes sleeping arrangements.

The correlated sample t-test showed that attitudes towards bedsharing scores (M = 5.23, SD = 0.85) were higher than attitudes towards solitary sleeping scores (M = 3.76, SD = 1.24) in mothers of intentional co-sleeping children, $t(414) = 17.57$, $p < .001$, $d = 1.03$.

The correlated sample t-test showed that attitudes towards bedsharing scores (M = 4.81, SD = 0.98) were higher than attitudes towards solitary sleeping scores (M = 4.60, SD = 0.89) in mothers of reactive co-sleeping children, $t(302) = 2.48$, $p = .002$, $d = .17$.

The correlated sample t-test showed that attitudes towards solitary sleeping scores (M = 4.71, SD = 1.11) were higher than attitudes towards bedsharing scores in (M = 4.59, SD = 1.06) mothers on solitary sleeping children, $t(322) = -1.28$, $p < .001$, $d = .09$.

Table 3.20

Summary of The Group Differences

Intentional Co-Sleeping Group

- Had younger children (on average)
- A higher rate of extended breastfeeding
- The most common sleep initiating methods were nursing and bedsharing
- More physical contact at night-wakes and "no interaction" choice was less reported for night-wakes
- 35% of them reported that they received criticism

- Mothers had favourable attitudes towards bedsharing than other groups
- Mothers had less favourable attitudes towards solitary sleeping than other groups

Reactive Co-Sleeping Group

- The most common sleep initiating methods were nursing and bedsharing
- Playing with the mother's arm or hair to sleep was more common than in other groups
- Taking the child to parental bed at night-wakes was more common than other groups
- Mothers reported less bedtime routine for 18-24 months old children (on frequency)
- Mothers reported a higher level of the perceived night wakes and settling problems than other groups (on frequency)
- 50% of mothers reported that they received criticism
- Mothers had a higher level of trait anxiety and a higher level of state anxiety than other groups
- Mothers had a higher level of attachment anxiety and a higher level of attachment avoidance than other groups
- Mothers had higher fear and frustration scores for the children than intentional co-sleeping and solitary sleeping children
- Mothers had lower soothability scores and higher activity level scores for children than mothers of solitary sleeping children

Solitary Sleeping Group

- Had higher household income level
- Children had a higher rate of schooling
- Lower rate of breastfeeding
- Bedtime routines have more frequently seen than other groups (other groups also have high rates)
- The most common sleep initiation method was bedsharing, and the second most common method was falling asleep in a crib/bed alone,
- Parental presence without bedsharing as a sleep initiation method was more common than in other groups
- Giving an object, talking, and "no interaction" responses at night wakes were more common than other groups
- More frequent transitional object use
- Mothers reported lower level of perceived night wake and settling problems than other groups (on frequency)
- 9% of them reported they received criticism

CHAPTER 4
DISCUSSION

The children's sleeping arrangements have been discussed as a psychological, socio-cultural, and medical issue for years. Researchers stated that children's sleep is affected by many factors like temperament, attachment, maternal behaviour, socio-cultural context, the family, etc. (Sadeh et al., 2010). The socio-cultural factors are the main factors that affect the children's sleeping arrangements (Jenni, 2005; Keller, 2008; Morelli et al., 1992; Shimuzi et al., 2014). Thus, the child factors and the parental factors are important to understand the within-culture differences in the children's sleeping arrangements. The current study aimed to investigate 18-48 months old Turkish children's sleeping arrangements in relation to the demographic factors, the children's temperament, the mothers' attitudes towards bedsharing and solitary sleeping, the mothers' anxiety level and attachment, the children's sleep practices, and the mothers' perception of child's sleep problems. The findings of the study provided detailed information about the children's sleeping practices in different sleeping arrangement groups. Besides, the present study is the first study examining the psychological factors relating to toddlers' sleeping arrangements in Turkey.

In the discussion part, first, the children's sleep practices and the mothers' perceptions of sleep problems will be discussed. Then, the results of the hypothesis testing will be addressed. Later, limitations and future directions will be presented. The clinical implications of the study will be discussed in the conclusion part.

4.1. DISCUSSION OF THE SLEEP PRACTICES OF THE CHILDREN

4.1.1. The Sleep Practices of the Children and Sleeping Arrangements

The total co-sleeping rate was 68.8% in this sample of 18-48 months old children. The rate decreased with age. These rates matched with the previous studies in Turkey (Kahraman & Ceylan, 2018, Karacal, 2010). However, the rate in the current study may be higher for 36-48 months old children. No research has reported the co-sleeping rate separately for 36-48 months olds in Turkey, but the co-sleeping rate was lower for 36-72 months old children in previous studies than the rate that was found in this study. (Gultekin & Temel, 2020; Karacal, 2010;

Ozvurmaz & Calisir, 2018). The difference may be due to sample size or sample characteristics. Since many participants volunteered for this study upon the announcement on social media, co-sleeping mothers might have been more interested in the study.

On the other hand, the co-sleeping percentage for preschool-age children may have increased due to the isolation in the pandemic. During COVID-19, the social isolation and health threat have affected people's well-being (Hessami et al., 2020). The children's physical activity and interaction with people outside the home have been restricted during the pandemic (de Araújo et al., 2020, Xiang et al., 2020). Children's emotion regulation difficulties and clingy behaviors were increased during COVID-19 (Di Giorgio et al., 2020; Jieo et al., 2020). Many children and their parents stayed at home together during the day and the night, influencing the parent-child relationship (Miho & Thévenon, 2020). In a qualitative study with Turkish parents, some parents reported that they had a closer relationship with their children during the pandemic comparing with before the pandemic. On the other hand, some parents reported the difficulty of being together with the children for 24 hours, and they expressed that dealing with the children's needs and emotions was stressful (Toran et al., 2021). The increased closeness between parents and children, and the emotion regulation difficulties of the children, the children's clingy behaviours may increase co-sleeping. Moreover, the restriction of the socio-emotional resources of children may impact the children's realization of their developmental potential (de Araújo et al., 2020). In general, co-sleeping is more common in younger children (Kahraman & Ceylan, 2018, Karacal, 2010; Okami et al., 2002). Therefore, it is possible that social isolation could lead to a delay in the beginning of children's solitary sleeping. Lui et al. (2020) found an increase in the co-sleeping rate for preschool children during the pandemic. On the other hand, Zreic et al. (2020) reported that children's sleeping arrangements did not change during the pandemic. Some researchers found that young children have slept better during isolation (Lui et al., 2020; Zreic et al., 2020), while some researchers found that the prevalence and intensity of young children's sleep problems has increased (Bruni et al., 2021; Lecuelle et al., 2020).

When co-sleeping was classified according to the beginning time of the co-sleeping practice, most co-sleeping children were classified as “early co-sleepers.” Keller and Goldberg (2004) used the term “early co-sleeping,” who continued co-sleeping practice since the infant was 0-12 months old, and “reactive co-sleeping” for the children who began co-sleeping after 12 months. They stated that “reactive co-sleeping” occurs as a solution to sleep difficulties. The parents choose co-sleeping in “early co-sleeping.” In Western societies, solitary sleeping is the norm even for infants (Sadeh et al., 2010). Researchers noted that co-sleeping is usually late-onset in the U.S., and it occurs due to sleep difficulties (Keller & Goldberg, 2004; Lozoff et al., 1984). However, the situation is different in the current study. Almost half of the early co-sleeping mothers indicated that they did not prefer co-sleeping in our research. Therefore, the classification of “reactive/intentional” (Ramos et al., 2007) that centered the sleep arrangement preferences of the parents fit this study more.

Intentional co-sleeping children were more likely to be younger than reactive co-sleeping children and solitary sleeping children. In Turkey, it can be said that most children begin to sleep alone when they are 2-5 years old if the findings of studies including sleeping arrangements are evaluated together (Baskale & Turan, 2017; Boran et al., 2014; Gultekin & Temel, 2020; Kahraman & Ceylan, 2018, Karacal, 2010). Researchers noted that reactive co-sleeping occurs in toddlerhood and after the child’s return to the parental bed (Lozoff et al., 1984). In the present study, the situation was similar, but reactive co-sleeping manifested itself with difficulty in separating beds rather than the child’s returning to the parental bed. The number of reactive co-sleeping children who returned the parental bed was low in the current study.

According to the previous studies, mothers of solitary sleeping children were more likely to have a higher income than co-sleeping children. Researchers consistently found that co-sleeping was more common in low SES families (Milan et al., 2007; Willinger et al., 2003; Keller, 2008, Ramos, 2001). In Turkey, Kahraman & Ceylan (2018) found that the percentage of solitary sleeping is higher in college graduate parents than high school or primary school graduate parents.

However, co-sleeping families mostly had a high-income level in this sample. There was little difference in the rates of income levels between groups.

Researchers indicated that co-sleeping is related to breastfeeding (McKenna et al., 2007). In the current study, mothers of intentional co-sleeping children had a higher rate of breastfeeding more than twice in comparison with mothers of solitary sleeping children. Extended breastfeeding was more common in the intentional-co sleeping group than the solitary sleeping group and the reactive co-sleeping group. Co-sleeping mothers of 18-24 months old children had a higher breastfeeding rate regardless of the type of co-sleeping than solitary sleeping children. These findings are consistent with the existing literature that explained the relationship between breastfeeding and co-sleeping (Gettler & McKenna, 2011; Marinelli et al., 2019; Salm-Ward, 2015).

The children's sleep initiating methods mainly included parental presence in the sample of the current study. The rates of nursing, holding, and bedsharing at sleep onset were high. On the contrary, the rates of sleeping alone and parental presence without bedsharing were low. The percentages of nursing and sleeping alone in a crib/bed at sleep onset differs between PA and PC countries. In PA countries, parental presence and nursing rates are higher than in PC countries (Mindell et al., 2010). The mother's responses to the children's night wakes showed a similar characteristic. Nursing, holding, and bedsharing were common maternal responses at night-wakes. The rate of holding the child at night-wakes was higher than three times compared to Mindell et al.'s study (2010). These findings cannot be generalized to the Turkish population. However, it can be proposed that young Turkish children have similar sleep onset practices with PA countries. Especially, the results provided preliminary information about Turkish children whose parents with high education level.

In Turkey, Kahraman and Ceylan (2018) conducted a study examining the sleep initiation behaviour of children. They collected data from mothers who came to hospitals and health centers in Karabuk Province. Their findings were different from this study. The rate of parental presence (e.g., nursing, bedsharing) was lower than in the present study. However, they found the co-sleeping rate as 73%, which

is close to the rate in this study. The difference between the two studies is considerable. It may be due to the differences in data collection methods and the sample characteristics between the two studies. The evident difference between the two samples was the average education level of parents. In the current study, the participants usually had a high education level. In Kahraman and Ceylan's study (2018), most participants were primary school or high school graduates.

In the current study, sleep onset behaviours and education level were not related. However, we found a relationship between bedtime routines and educational level, as previous studies have indicated (Covington et al., 2019; Hale et al., 2010). Parents who had higher education levels more frequently reported that their children had a bedtime routine such as reading a book, massaging, bathing, etc. Thus, the education level might be a factor relating to Turkish children's sleep practices. A positive relationship between the higher education level of parents and more parental involvement at sleep onset is possible. It would be in line with the existing literature about the structure of Turkish families. Fisek (1991) found that high SES families with higher education levels showed more proximity than low SES families in Turkey. The measurement of "proximity" included touching as an indicator of emotional relatedness. Thus, co-sleeping may be a tradition in low SES families in Turkey rather than an indicator of emotional relatedness.

The dominant sleep onset practices of the children differed between sleeping arrangements. The nursing rate was highest for intentional co-sleeping mothers. Reactive co-sleeping children also had a higher rate of nursing as sleep onset behaviour than solitary sleeping children. The nursing rate in solitary sleeping children was also higher than the rate in Mindell et al.'s (2010)'s large cross-cultural study. Most children, including solitary sleepers, fell asleep by bedsharing. One of the differences in sleep practices between sleeping arrangements was the practice of bedtime routines. 18-24 months old reactive co-sleeping children less frequently had bedtime routines. Solitary sleeping children were more likely to have a bedtime routine than co-sleeping children in total. However, bedtime routines were asked by parents via a single-item question. Sleep diaries and detailed recordings are required for more reliable information.

The mother's responses to the children's night wakes were varied in all sleeping arrangements. In general, intentional co-sleeping mothers responded to the night wakes with more physical proximity than the mothers of solitary sleeping and reactive co-sleeping children. The responses like talking, giving an object were more common in solitary sleeping children's mothers than co-sleeping children's mothers.

These findings are very different from the Western countries that showed low percentages of co-sleeping, parental presence of sleep onset, and nursing/feeding to sleep (e.g., Mindell et al., 2010, 2012; Okami, 2008; Sadeh et al., 2009). It is consistent with the family and child-rearing characteristics in Turkey. Kagitcibasi (2007) indicated that Turkish families are emotionally interdependent. In such cultures, physical contact, extended breastfeeding, and co-sleeping are more common than in individualistic societies (Feldman et al., 2006; Keller, 2003; Rothbaum, Pott, et al., 2000). For instance, co-sleeping has been the norm in Japan and South Korea (Iwata et al., 2013; Mindell et al., 2013). However, there is uncertainty about what the sleeping arrangement norm in Turkey is. Co-sleeping families were the majority in all studies (Kahraman & Ceylan, 2018, Karacal, 2010). On the other hand, mothers reported that they were criticized for co-sleeping. Moreover, a significant number of co-sleeping mothers said that they did not feel satisfied with co-sleeping. Some mothers have separated their beds, and some of them also reported that they were criticized. Yet, 35% of intentional co-sleeping mothers and 50% of reactive co-sleeping mothers reported that they were criticized for co-sleeping. This difference showed the individual or contextual differences of perception of the criticism. However, co-sleeping mothers felt more criticized than solitary sleeping children's mothers in the present study. Howson (2018) mentioned that the co-sleeping debate assumes mothers were vulnerable and lead moral judgments about mothers. In this study, reactive co-sleeping mothers could be affected by these moral judgments more.

The important point is that many Turkish children begin to sleep alone when they are 2-5 years old, according to the research evidence (Baskale & Turan, 2017;

Boran et al., 2014; Gultekin & Temel, 2020; Kahraman & Ceylan, 2018, Karacal, 2010) so the sleeping arrangements of the toddlers and preschoolers varied.

Since there is not a specific norm about the toddlers' sleeping arrangements in Turkey, another problem is interpreting the correlates of co-sleeping in Turkey. Co-sleeping literature addressed cultural norms to analyze the correlates of co-sleeping (i.e., Daws, 1989; Lozoff et al., 1985; Luijk et al., 2013). Neophytou et al. (2020) mentioned the "normalizing effect of culture" for the mixed evidence about the associations between mental health problems and co-sleeping. Some researchers underlined parental preferences in addition to culture because some parents choose co-sleeping as a counter-cultural child-rearing practice in the U.S and Europe (Keller & Goldberg, 2004). However, co-sleeping is not always desired or acceptable, although it is common for the participants in this sample. Therefore, cultural norms are not the only key in interpreting the correlates of co-sleeping for this study. Individual differences are significant. According to the results of this study, both reactive co-sleeping and intentional co-sleeping may be common in Turkey, unlike Western or Eastern countries. Ramos (2001) emphasized the individual-level factors even for the U.S. She found that individualism-collectivism scores were not related to co-sleeping in an American sample (Ramos, 2001).

4.1.2. The Mothers' Perceptions of Sleep Problems and Sleep Practices

35% of mothers reported that their child waked at night. It is similar to existing research about toddler sleep norms (Blair et al., 2012; Crowell et al., 1987; Zuckerman et al., 1987). Some researchers reported higher night-wake rates than 35% (Hysing et al., 2016; Karacal, 2010; Ozvurmaz & Calisir, 2018). The rate of the children who slept through the night was higher for solitary sleeping children, which is consistent with many previous self-report studies (Volkovich et al., 2015. However, a study comparing the actigraphy and self-report findings showed that the number of the night wakes differed across sleeping arrangements only for self-report (Volkovich et al., 2015). Actigraphy studies are more reliable for measuring the accurate number of night-wakes. Another point about night wakes was the breastfeeding status of children. The frequency of breastfeeding was higher in co-sleeping mothers. There was also a correlation between the weaning age and the

child's age who began sleep through the night in the current study. Researchers showed that infants and toddlers who are breastfed wake at night more frequently (Elias et al., 1986). On the contrary, some found nursing to sleep was related to higher number of the night wakes than breastfeeding after 6-9 months (Brown & Harries, 2015; Mindell et al., 2012). Still, breastfeeding mothers are usually nursed to sleep in this sample. The night wakes could be related to nursing at some part.

Some researchers emphasized the parental perceptions of sleep problems rather than the exact number of night wakes in the definition and intervention of the sleep problems of the young children (Goldberg et al., 2013; Lozoff et al., 1985; Sadeh, 2004). This study did not include the number of the night wakes. Instead, the mothers' perceptions about night wakes were included. In the present study, the rate of perceived sleep problems was parallel with the previous studies in Turkey (Boran et al., 2014, Kahraman & Ceylan, 2018; Karabekiroglu et al., 2013). Mothers of reactive co-sleeping children perceived a high level of night-wake problems in their children more frequently than mothers of intentional co-sleeping mothers and mothers of sleeping children. Researchers have found the same consistently (Germo et al., 2007; Keller & Goldberg, 2004; Ramos, 2001; Ramos et al., 2007). Thus, a characteristic of reactive co-sleeping was the mothers' perception of problematic sleep behaviour. Mothers of solitary sleeping children were less likely to report high level perceived sleep problems than co-sleeping mothers. It was also consistent with research evidence, including the maternal perceptions of sleep problems (Germo et al., 2007; Keller & Goldberg, 2004). The frequency of taking parental bed as a response to the child's night wake was higher in reactive co-sleeping children's mothers than intentional co-sleeping mothers. Researchers described reactive co-sleeping children as the children who come to the parental bed to sleep or who cannot sleep alone (Keller & Goldberg, 2004; Madansky & Edelbrock, 1990; Ramos et al., 2007). In this sample, some reactive co-sleeping children were taken to parental bed after night wakes, and this finding was in line with the existing literature.

Reactive co-sleeping mothers also perceived a big settling problem in their children more frequently than intentional co-sleeping mothers and solitary sleeping

children's mothers. On the other hand, solitary sleeping children's mothers perceived fewer settling problems than co-sleeping mothers. It is consistent with the previous findings (Keller & Goldberg, 2004; Germo et al., 2007; Ramos, 2001).

Researchers indicated that nursing/feeding the child to sleep is the strongest predictor of waking problems (Brown & Harries, 2015; Mindell et al., 2010, 2012). The frequency of nursing as a response to night wakes was lower in the mothers of reactive co-sleeping children than intentional co-sleeping children. The reactive co-sleeping mothers reported more night-wake and resistance problems. This is to say, maternal perceptions of sleep problems also had other predictors than nursing or feeding to sleep. On the other hand, solitary sleeping children's mothers perceived fewer sleep problems than co-sleeping mothers. Their behaviours included less physical proximity at sleep time. It is consistent with research evidence of sleep problems (Gradisar et al., 2016; Mindell et al., 2010; Sadeh et al., 2009; Touchette et al., 2005). It can be said that mothers had unique experiences of nursing to sleep and night wakes. However, this study only examined to what extent the children's sleep difficulties were a problem for the mothers, and it can only give an idea. Future qualitative studies and quantitative studies with actigraphy or sleep diaries can provide more information.

4.2. DISCUSSION OF THE RESULTS OF THE HYPOTHESIS TESTING

4.2.1. Maternal Attitudes Towards Sleeping Arrangements

One of the aims of this study was to understand the relationship between maternal attitudes towards sleeping arrangements and the children's sleep arrangements. It was hypothesized that mothers of intentional co-sleeping children would favour bedsharing more than mothers of solitary sleeping children and reactive co-sleeping children, and they would have lower scores on attitudes towards solitary sleeping than the mothers in other groups. Secondly, it was hypothesized that mothers of solitary sleeping children would favour solitary sleeping more than the mothers of reactive co-sleeping children. It was also expected that mothers of reactive co-sleeping children would have higher scores on attitudes towards bedsharing than mothers of solitary sleeping children.

Only the first hypothesis was supported. Only the intentional co-sleeping group differed in terms of maternal attitudes towards sleeping arrangements. They had more positive attitudes towards bedsharing and less positive attitudes towards solitary sleeping than reactive co-sleeping and solitary sleeping groups. Mothers of reactive co-sleeping children and mothers of solitary sleeping children did not significantly differ in their bedsharing or solitary sleeping attitudes. These findings were partly consistent with the results of previous studies. Previous studies found that intentional (early) co-sleeping mothers had higher scores on their positive attitudes towards bedsharing and lower scores on their positive attitudes towards solitary sleeping than mothers of solitary sleeping children and mothers of reactive co-sleeping children. However, they also found the maternal attitude scores in the reactive co-sleeping group were between the other two groups and showed a significant difference from other groups (Germo et al., 2007). Some found that reactive co-sleeping and intentional (early) co-sleeping mothers did not differ in their attitudes. Still, early bedsharing mothers had more positive attitudes towards bedsharing than solitary sleeping children's mothers and reactive co-sleeping mothers (Keller & Goldberg, 2004). In the present study, the participants had been asked for their preference of children's sleeping arrangements and their satisfactions to differentiate reactive and intentional co-sleepers. The intentional co-sleeping group was distinguished from the reactive co-sleeping group in terms of maternal attitudes, indicating that the PSAS could separate the intentional and reactive group, and it was consistent with the mothers' preferences.

The psychometrics of the original scale and the revised scale differed in several aspects. Item 2 ("It feels terrible for parents to have to listen to children cry themselves to sleep."), and Item 4 ("Children will lose trust in their parents if they cry at night and the parents don't respond to the crying.") was excluded because of the ceiling effect. It showed that the children's crying at night evokes negative emotions for the parents who participated in this study, and the children's crying at night-time is an important signal that must be responded to for the participants in the current study sample. The participants in the current study were interested in the study and they volunteered to participate, which is about the closeness of the

mothers and children. They were probably sensitive mothers. On the other hand, it can address one of the cultural characteristics of emotional relatedness. For example, in Japan, parents aim to reduce the child's distress immediately, and they do not wait for the expression of the distress, unlike the parents in the U.S. (Rothbaum, Weisz, et al., 2000).

The item "Bedsharing is harmful to 6-month-olds if they witness parental intimacy" was excluded because the communality was low for this item. This item was not related to the maternal attitudes towards the children's sleeping arrangements for the sample of the current study. The fact that this item is about 6 months old infants may be one of the reasons for this. In many Western countries, infants began to sleep in separate rooms at 6 months (Hauck et al., 2008; Mindell et al., 2010; Morelli et al., 1992). Therefore, this item can be more suitable for Western families. The item "Bedsharing prevents a couple from experiencing intimacy and privacy" was stable in the revised subscale of "Attitudes Towards Solitary Sleeping." Thus, the age of the infant/child may be a factor for the beliefs about the infants/children witness of the couple's sexual intimacy in Turkish culture.

Another psychometric difference between the original scale and the revised one was the strength of the association between subscales. In the original form, the subscale of attitudes towards bedsharing and the subscale of attitudes towards solitary sleeping had a strong negative correlation (r = -.73) (Keller & Goldberg, 2004). In the current study, the subscales had a weak negative correlation (r = -.36). Some of the participants in the sample had both positive attitudes towards bedsharing and positive attitudes towards solitary sleeping. However, they showed differences in their favourable attitudes. Intentional co-sleeping mothers showed more within-group and between-group differences in their attitudes towards bedsharing and attitudes towards solitary sleeping. Reactive co-sleeping and solitary sleeping groups showed only within-group differences in their attitudes, but the effect size was small. Attitudes towards bedsharing included questions about 6-months infants. The study included the mothers of 18-48 months old children. Previous studies used the scale for the mothers of preschoolers. They also found

strong correlations between subscales (Germo et al., 2007; Keller & Goldberg, 2004). In Turkey, most of 6-months olds co-sleep (Baskale & Turan, 2017; Boran et al., 2014; Kahraman & Ceylan, 2018). This situation can explain that the attitudes towards bedsharing tend to be positive in the solitary sleeping group. Another scale, including questions about the toddlers' co-sleeping, will be more beneficial in investigating maternal attitudes towards toddler-parent co-sleeping.

Therefore, it can be suggested that conflictual attitudes of individuals play a role in the difference of the correlations' strength. Fisek (2018) indicated that conflictual tendencies and beliefs about relatedness and separateness exist in Turkish individuals with an expanding self due to social change. In expanding the self the interdependent core of the self does not change, but it expands, and the self becomes multicultural (Fisek, 2018; Roland, 1988, as cited in Fisek, 2018). Similarly, Shimizu et al. (2014) showed the effect of social change in Japanese co-sleeping mothers' beliefs and feelings about co-sleeping. Japanese mothers reported conflict about their practice of co-sleeping. In the current study, reactive co-sleeping mothers had a conflict between their preferences and attitudes. On the contrary, intentional co-sleeping mothers seem to have less conflictual opinions about sleeping arrangements. They prefer co-sleeping, and they favoured co-sleeping.

The sample characteristics showed that participants were primarily well-educated, and they had a relatively high income. Researchers indicated that educated individuals in urban Turkey assimilate individualistic values (Kagitcibasi, 1996; Imamoglu, 2003). In individualistic societies, intentional co-sleeping shows a chosen, counter-cultural practice (Keller & Goldberg, 2004). However, researchers consistently found that co-sleeping is the most common sleeping arrangement of toddlers in Turkey. These studies included low SES and high SES families (Gultekin & Temel, 2020; Kahraman & Ceylan, 2018; Karacal, 2010). Thus, we cannot distinguish whether intentional co-sleeping reflects a tradition or a chosen practice in the current study sample.

Another question is that the chosen co-sleeping practice is counter-cultural or not for well-educated individuals in Turkey. It may be somewhat counter-

cultural. Reactive co-sleeping mothers reported that they felt criticized more frequently than other groups. Intentional co-sleeping mothers also reported that they received criticism, but they seem to agree on co-sleeping. It can be speculated that Western values have influenced Turkish mothers regarding their children's sleeping arrangements. However, a low percentage of mothers favoured solitary sleeping in this study. A relatively low rate of mothers separated the children's beds before the age of 4-5 in all existing studies conducted in Turkey. Still, co-sleeping in toddlerhood includes conflict for some mothers. They reported that they were not satisfied with their co-sleeping practice.

4.2.2. Maternal Attachment Insecurity and Maternal Anxiety in Different Sleeping Arrangement Groups

It was hypothesized that maternal attachment avoidance and maternal attachment anxiety would be higher in reactive co-sleeping children's mothers than intentional co-sleeping children's mothers and solitary sleeping children's mothers. As expected, both maternal attachment avoidance and maternal attachment anxiety were higher in the mothers of reactive co-sleeping children.

Another hypothesis of this study was that both the trait anxiety levels and the state anxiety levels would be higher in reactive co-sleeping children's mothers than intentional co-sleeping children's mothers and solitary sleeping children's mothers. As expected, the anxiety levels were higher in mothers of reactive co-sleeping children than the mothers in the intentional co-sleeping and solitary sleeping groups.

It was also hypothesized that mothers of intentional co-sleeping children would have higher attachment anxiety than mothers of solitary sleeping children. This hypothesis was not supported. Maternal attachment anxiety did not show a difference between mothers of solitary sleeping children and mothers of intentional co-sleeping children. Similarly, the hypothesis of that maternal trait and state anxiety would be higher in mothers of intentional co-sleeping children than mothers of solitary sleeping children was not supported. Intentional co-sleeping mothers did not significantly differ from solitary sleeping children's mothers in terms of anxiety levels.

Researchers explained that reactive co-sleeping mostly occurs because of the children's sleep problems (Mileva-Seitz et al., 2016). The frequency of reporting a high level of sleep problems was higher for reactive co-sleeping mothers than intentional co-sleeping mothers and solitary sleeping mothers. The findings of this study indicated that mothers of reactive co-sleeping children were relatively anxious. The mean trait anxiety score of the reactive co-sleeping group corresponded to a high level of anxiety (Kayikcioglu et al., 2017). Reactive co-sleeping in this sample had some characteristics of co-sleeping in the sleep problem literature that included co-sleeping as a sleep problem (Bayer et al., 2007; Covington et al., 2013; Richman, 1981). Covington et al. (2018) found co-sleeping mothers perceived more sleep problems and they had more anxiety and stress. Researchers found that maternal anxiety, maternal distress, and child sleep problems are related (Seifer et al., 1996; Thome & Skuladottir, 2005). All these studies were correlational. Namely, mothers of reactive co-sleeping children experienced a problem with co-sleeping. Mothers' high anxiety levels may increase the sleep problems of children that resulted in reactive co-sleeping, or the presence of this problem may increase the anxiety of the parents. On the other hand, Goldberg et al. (2013) stated that anxious mothers perceived common infant sleep behaviours as more problematic regardless of the actual amount of infants' sleep disturbance. Similarly, Teti and Crosby (2012) found that depressive mothers misinterpreted the infant’s cues and exhibited overinvolvement behaviour at night. Therefore, the direct effect of maternal anxiety in perceived sleep problems and undesirable co-sleeping is possible.

Many researchers described that reactive co-sleeping is late-onset and occurs as a response to sleep problems (Keller & Goldberg, 2004; Mileva-Seitz et al., 2016). However, most of the reactive co-sleeping children were early co-sleepers, and some of them were late-onset co-sleepers who began co-sleeping after 12 months. This is to say, the child’s sleep problems alone cannot explain the reactive co-sleeping in this case. Besides, these mothers had conflictual attitudes about co-sleeping, and they may be anxious about separating the beds. In accordance with this, both maternal attachment anxiety and maternal attachment

avoidance were found to be relatively higher in reactive co-sleeping mothers. These findings are consistent with previous findings indirectly. A study found no relationship between 6-months old infants' sleeping arrangements and mothers' attachment (Jones et al., 2020). Still, Benoit et al. (1992) found that all mothers who consulted for toddler sleep problems had insecure attachment styles in their case-control study. They used the Adult Attachment Interview. Benoit et al.'s study (1992) noted that sleep problems included the child's coming to the parental bed.

On the other hand, researchers did not find any relationship between maternal insecure attachment and 9-15 months infant sleep problems when they used self-report measurement of maternal attachment (Burnham et al., 2002; Scher & Dror, 2003). In the current study, reactive co-sleeping had higher scores on maternal attachment insecurity than other mothers. One reason for this difference may be that the present study consists of 18-48 months old children. The age of children is essential in the relationship between attachment-related factors, and child sleep disturbances are common in infancy. For instance, maternal sensitivity was related to sleep disturbances for 2-4 years old children, but it was not related to 12-18 months old infants (Tetreault et al., 2016). Another reason is that reactive co-sleeping is directly associated with closeness and separateness compared with other sleep problems. Moreover, reactive co-sleeping may be related to the couple's relationship at some part. Some of the co-sleeping mothers slept separately from their partners regardless of the type of co-sleeping. Researchers found associations between marital dissatisfaction and co-sleeping (Germo et al., 2007; Messmer et al., 2012; Song, 2010; Teti et al., 2015).

Mothers of reactive co-sleeping children had a conflict about closeness and separateness. Attachment anxiety includes separation anxiety, fear of abandonment, and attachment avoidance includes being uncomfortable with closeness (Brennan et al., 1998). These constructs were about romantic attachment. Still, researchers found associations between parenting and adult romantic attachment insecurity (Cohen et al., 2011; Goodman et al., 1997; Millings et al., 2012; Rholes et al., 2006; Selcuk et al., 2010).

Daws (1989) explained that mothers are angry about not being able to separate with their children at sleep time, and they tend to fear that if they separate, they will completely be detached. Therefore, separation anxiety increases. The high trait anxiety and high attachment anxiety can be an indicator of separation anxiety. Maternal separation anxiety and insecure adult romantic attachment of mothers were related (Mayseless & Scher, 2000; Vasquez et al., 2002). Maternal trait anxiety is also associated with maternal separation anxiety (Hock et al., 1989).

Children need a sense of security to initiate sleep (Dahl, 1996; Keller & El-Sheikh, 2011). Ambivalent and inconsistent messages about sleep time could negatively influence the toddlers' sense of security. It cannot be said that reactive co-sleeping children were insecure children. However, their sleep practices were inconsistent comparing with other groups. Moreover, the mothers of reactive co-sleeping had an ambivalence about co-sleeping. Main and Stadtman (1981) explained that mothers' rejection of physical contact causes more negative emotions like anxiety and anger in the infant. Infant demands more closeness to get calm, and the mothers find more difficult to calm the infants. The reactive co-sleeping toddlers and their mothers may experience a similar problem.

According to the mothers' self-report, reactive co-sleeping children were more likely to have difficulty settling to sleep. Sleep time is a transition time that includes a separation for the mother and the child (Anders, 1994). Attachment literature also explained that insecure mothers had difficulty understanding and attuning their infants' negative emotions. (Haft & Slade, 1989; Main et al., 1989). Maternal attachment security predicts the mothers' emotional availability and the child's negative emotion regulation (Feldman et al., 2011). Researchers found that 2 years old children who had insecurely attached mothers had more difficulty regulating the fear (Coppola et al., 2015). Maternal trait anxiety is also related to less maternal sensitivity, incongruent responses to the child, and intrusiveness (Beebe et al., 2011; Feldman, 1997; Hinde et al., 2013; Kertz et al., 2007; Shin et al., 2008). Therefore, emotion regulation at sleep time and after night wakes may be difficult for these children.

Contrary to expectations, intentional co-sleeping mothers did not significantly differ in their anxiety and attachment insecurity scores comparing with the mothers of solitary sleeping children. The rationale of this expectation was that co-sleeping indicates more relatedness, and relatedness associates with higher attachment anxiety (Friedman et al., 2010). Another explanation was that researchers have found that a lower level of maternal separation anxiety is associated with less parental involvement and less physical proximity with the infant's sleep at night (Scher, 2008; Scher & Blumberg, 1999). Co-sleeping mothers, including early co-sleepers, have higher maternal separation anxiety than solitary sleeping mothers (Dwyer, 2016; Keller, 2008). Similarly, mothers who slept in kibbutz communal houses practice co-sleeping more than mothers who slept in their parents' home to indicate past experiences' effect on chosen sleeping arrangements (Aviezer & Scher, 2013; Tikotzky et al., 2010). However, the related factors of intentional co-sleeping were breastfeeding status, the child's age, and the maternal attitudes in this study. Intentional co-sleeping mothers preferred co-sleeping, they were satisfied with co-sleeping, and they had positive attitudes towards co-sleeping. Moreover, they had more negative attitudes towards solitary sleeping. This is to say; they believe the best sleep arrangement is co-sleeping for them. Accordingly, there was no correlation between maternal attitudes towards bedsharing and attachment anxiety, trait anxiety, or state anxiety.

Luijik et al. (2013) conducted a cross-cultural study with Dutch, Moroccan, and Turkish families living in the Netherlands. They found that co-sleeping was associated with maternal mental health issues only in Dutch families (Luijik et al., 2013). Interestingly, reactive co-sleeping related to maternal mental health problems and seen in Western societies was also common in the present study. On the other hand, the characteristics of intentional co-sleeping mothers were consistent with the co-sleeping Turkish mothers in Luijik et al.'s study (2013). Furthermore, researchers showed the difference between intentional co-sleeping and reactive co-sleeping in Western societies (Germo et al., 2007; Keller & Goldberg, 2004; Ramos et al., 2007). For instance, Keller & Goldberg (2004) found that middle-to upper-class intentional co-sleeping mothers had higher scores on

autonomy support than mothers of reactive co-sleeping and mothers of solitary sleeping children in the U.S. Considering the emotionally-related self of Turkish individuals, intentional co-sleeping and solitary sleeping in Turkish well-educated families is open to more investigation

Another important issue at this point is the relationship between attachment and the culture. The expressions of security and insecurity change across different cultures (Rothbaum, Weiss, et al., 2000). Halfon (2006) conducted a study with a Turkish sample, and she found that attachment security has a negative correlation with autonomy and expanding self. Fişek (2018) explained that expanding self includes a conflict between the related self: preverbal and implicit, and the independent-oriented values, which are cognitive and learned. The self-report measures of attachment use explicit knowledge (Crowell & Treboux, 1995), emphasizing autonomy (Friedman et al., 2010). Thus, the Turkish individuals' report on independence-oriented self-report measures of attachment may reflect the culture-related conflict (Halfon, 2006). Children's sleeping arrangements are related to the culture (Jenni & O'Connor, 2005; Morelli et al., 1992; Shimuzi et al., 2014, Song, 2010). Mothers of reactive co-sleeping children had conflictual attitudes. They also had higher scores on both attachment avoidance and anxiety. Gaskings et al. (2017) argued the need of culture-specific attachment measures, and they underlined the combination of qualitative and observational methods to investigate the expression of attachment in different cultures. Because independence-oriented self-report measures of attachment may also reflect the culture-related conflicts, observational or projective methods of measuring attachment could give purer information about the relationships between attachment, parent-child relationship, and sleep.

On the other hand, attachment anxiety has been found as higher than attachment avoidance in Eastern societies due to emotional relatedness (Friedman et al., 2010). In the present study, the average score of attachment anxiety was higher than the average score of attachment avoidance. However, intentional co-sleeping children's mothers did not show a significant difference in their attachment anxiety scores than solitary sleeping children's mothers, questioning the

relationship between autonomy, attachment, and sleeping arrangements. This situation is in line with the previous research that could not find a connection between attachment and sleeping arrangements (Jones et al., 2020; Keller, 2008), and the study that found the positive interaction between the infant and parent who predicted stable sleeping arrangement (Taylor et al., 2008). These findings showed the importance of intentional-reactive distinction in co-sleeping research as previous studies showed (Germo et al., 2007; Keller & Goldberg, 2004; Messmer et al., 2012; Ramos et al., 2007). Still, it is important to note that the constructs of the romantic attachment scale and observational measures of mother-child interaction were different. As an additional indicator of the importance of intentional-reactive distinction regarding the romantic relationship of the mother, studies about the couple's relationship also indicated that marital role satisfaction is lower only for reactive co-sleeping children's parents, not for intentional co-sleepers (Germo et al., 2007; Messmer et al., 2012).

4.2.3. Children's Temperament in Different Sleeping Arrangement Groups

One of the hypotheses of this study was that the child's temperament would be related to the sleeping arrangements. As expected, mothers of reactive co-sleeping children reported higher scores on frustration, fear, activity level dimensions of child temperament than mothers of intentional co-sleeping and solitary sleeping children, and reactive co-sleeping children's mothers reported lower scores on soothability dimension of child temperament than solitary sleeping children's mothers. Contrary to expectations, the perceptual sensitivity scores did not differ between sleeping arrangement groups.

In previous research, many researchers found that difficult temperament is related to settling difficulties and night-wake problems (Atkinson et al., 1995; Jimmerson, 1991; Morell & Steele, 2003; Weinraub et al., 2012). Hayes et al. (2001) found that reactive bedsharing is related to a different temperament. Thus, the findings of this study have been in accordance with the previous evidence. The reactive co-sleeping children were reported to be temperamentally more reactive and less soothable. They may need intense support to get calm, and this situation may strain the parents.

In the present study, perceptual sensitivity did not differ between sleeping arrangement groups. This is because reactive co-sleeping and sleep problems are different concepts. Still, this finding is partly consistent with previous research if reactive co-sleeping is assumed as an indicator of sleep difficulties. Carey (1974) found that sensory sensitivities is related to sleep problems. Carey's (1974) study was conducted with 6-12 months old infants. Hayes et al. (2001) found no association between reactive co-sleeping and perceptual sensitivity for 3-6 years old children. Therefore, one explanation of the discrepancy can be that infants may affect sensory sensitivities during sleep time more than toddlers. On the other hand, researchers found that the toddlers' sensory sensitivities and settling difficulties are associated when they used sensitive measures of sensory processing (Appleyard et al., 2020; Vasak et al., 2015). Therefore, the measurement tool used in the present study can be one reason why perceptual sensitivity did not differ between the sleeping arrangements.

Soothability scores were higher in solitary sleeping children than reactive co-sleeping children. Children who were breastfed currently had higher soothability scores and lower frustration and fear scores than children who were not breastfed currently. Therefore, it can be said that breastfeeding children had an easier temperament, according to the mothers' report. The breastfeeding rate was higher for intentional co-sleeping children, and intentional co-sleeping children had the highest scores on soothability before the breastfeeding status was controlled. These findings are compatible with that intentional co-sleeping mothers perceived fewer sleep problems than reactive co-sleeping children.

Another point was that the mothers' attachment anxiety, attachment avoidance, trait anxiety, state anxiety, and the child's frustration, soothability, and fear scores were correlated. Researchers suggested the interactional and transactional models of temperament and parenting (Kiff et al., 2011). There have also been correlational studies that showed the relationship between child temperament and parenting (Kochanska et al., 2004). Anxious mothers could perceive the child's temperament as more difficult, or they could affect the child's

temperament. Nonetheless, this difficult temperament played a role in the reactive co-sleeping situation.

4.3. LIMITATIONS OF THE STUDY AND FUTURE DIRECTIONS

The large sample size was a strength of this study. However, participants were reached via social media, the researcher's contacts, and some convenient preschool communities. The participants were interested in the topic, and they volunteered to participate in the study. Moreover, most participants were well-educated, and many of them were from high SES families. Using random sampling or a convenient sample from several public places (i.e., health centers) could provide more generalizability. This study provided important findings of the psychological factors relating to the sleeping arrangements of Turkish children whose parents have a high education level.

Data were collected during the second year of the COVID-19 pandemic. The condition of the pandemic was a limitation of generalizability.

The reasons for the sleeping arrangements and the number of rooms in the houses were not included in the survey questions. However, some children may sleep in the same room with their parents because of the limited space. Therefore, further studies should include the reasons for the sleeping arrangements and the house conditions.

The sleep difficulties of the children and the sleep practices were asked in single-item forms. Parental perceptions of child sleep problems and child sleep practices have been asked parents in a single-item scale or multiple-choice format in many studies (Keller & Goldberg, 2004; Mindell et al., 2010; Sadeh et al, 2009, Sadeh et al., 2011). Yet, the sleep diaries, actigraphy records, and sleep problem scales will give more objective information about sleep practices and sleep problems.

The responses could be biased because self-report scales were used. Using counterbalancing, using observation methods for the measurement of the child's temperament, and using the Adult Attachment Interview for the measure of mothers' attachment could provide less biased results. On the other hand, using a romantic attachment measure provided examining and interpreting the mothers'

current experiences of close relationships. It gave information about the mothers' attachment system rather than the child's attachment. However, it brings some measurement problems as to which close relationship experience is being measured (Fraley et al., 2011). Using an observational method of measuring the parent-child relationship could provide additional and clear information about the relations between the mother-child attachment and sleep.

The Attitudes Towards Bedsharing Subscale in the PSAS (Keller & Goldberg, 2004) included questions about 6 months old infants. Other researchers used this questionnaire with the mothers of preschool children (Germo et al., 2007; Keller & Goldberg, 2004). However, the sixth month is not the time for separating the infant's room in Turkey, unlike the Western countries. Thus, another scale including questions about toddlerhood could be more suitable to assess the parental attitudes of the children's sleeping arrangements.

The EBCQ is designed primarily for toddlers whose ages were between 18 and 36 months (Putnam et al., 2006). The online data collection in pandemic conditions was the obstacle of using a different temperament scale (e.g., CBQ: Rothbart et al., 1994) for 36-48 months old children.

Further qualitative studies could give more information about the reasons for the sleeping arrangements. There are many questions that this study could not answer, such as whether intentional co-sleeping is a tradition or a choice, is separating beds difficult for the co-sleeping parents, why do parents feel criticized, etc. Another critical issue is the fathers. An intra couple research could give broader information about the psychological factors related to the children's sleeping arrangements.

4.4. CONCLUSION AND CLINICAL IMPLICATIONS

The current study is the first study in Turkey examining the children's sleeping arrangements from a psychological viewpoint. The study showed that co-sleeping is common in young Turkish children, as previous research demonstrated. Researchers indicated that co-sleeping is mostly intentional in Eastern societies, and mostly reactive in Western societies (Lozoff et al., 1985; Luijik et al., 2013). Both intentional co-sleeping and reactive co-sleeping were common for Turkish

families in the current study. Solitary sleeping was also seen. Co-sleeping children's mothers reported that they were received criticism more frequently than solitary sleeping children's mothers. Researchers stated that cultural norms are the key in interpreting the children's sleeping arrangements regarding family functioning and the family members' mental health (Luijik et al., 2013; Neophytou et al., 2020). However, the findings of this study demonstrated that it is not clear what is the norm of the toddler's sleep arrangements in Turkey. This is probably since most children begin sleeping alone in toddlerhood in Turkey. Diversity is seen in toddler's sleeping arrangements, and many mothers experience separation difficulties. It may also reflect the culture-related conflict about separation and closeness in the educated individuals in Turkey.

Nonetheless, Freud (1962) described transient developmental strains which do not indicate psychopathology. Reactive co-sleeping can be interpreted as a transient developmental difficulty the mother-child dyad experience. Still, the individual differences in the sleeping arrangement attitudes were important in interpreting the toddler's co-sleeping in the present study.

The maternal sleep attitudes discriminated intentional co-sleeping group from reactive co-sleeping and solitary sleeping group. Intentional co-sleeping mothers favoured bedsharing rather than solitary sleeping. They were more likely to have longer breastfeeding durations.

Mothers of reactive co-sleeping children reported a higher level of perceived sleep problems more frequently than intentional co-sleeping and solitary sleeping children's mothers. Solitary sleeping children's mothers were less likely to report sleep problems. Parental presence and bedsharing at sleep onset were common for all children. Relatively- distal parental support like talking was seen in solitary sleeping children. Nursing and feeding at sleep onset and night-wakes were seen more frequently in the intentional co-sleeping group than reactive co-sleeping and solitary sleeping groups.

The maternal anxiety, the mother's attachment insecurity, and the child's difficult temperament discriminated the reactive co-sleeping group from the intentional co-sleeping and solitary sleeping groups. The state anxiety level of the

mother, the trait anxiety level of the mother, the frustration level of the child, the mother's attachment avoidance, the fear level of the child, the mother's attachment anxiety, and the activity level of the child were higher in reactive co-sleeping children, sorting from the larger effect size to smaller effect size. Breastfeeding mothers reported high scores on soothability of the children. Soothability scores were higher for the intentional co-sleeping group than other groups. However, solitary sleeping groups had the highest soothability score when the breastfeeding status was controlled.

In summary, mothers of reactive co-sleeping children were anxious, and they felt relatively insecure in their close relationships. They perceived the children's temperament as difficult, and they perceived more sleep problems. They can benefit from psychological support. The interventions focusing on the mother's relational anxiety and the parent-child relationship may be efficient. The reactive co-sleeping mothers reported that they felt criticized. Howson (2018) stated that the judgments about sleeping arrangements make the mothers vulnerable. The moral judgments and directions about sleeping arrangements would make the mothers feel less competent and lead to more conflict. On the other hand, Goldberg et al. (2013) noted that anxious mothers perceived more sleep problems and could have unrealistic expectations. They emphasized the importance of giving information about normal infant sleep to the parents. Thus, giving evidence-based information about the outcomes and predictors of the sleeping arrangements and normal toddler sleep can be useful for conflict resolution. If the parents are sure that they want to separate the child's bed, supporting interventions, including behavioural advice, can be helpful in addition to the interventions as mentioned above.

Intentional co-sleeping mothers had lower anxiety levels and lower attachment insecurity scores. It can be speculated that they will not experience the separation as complicated as the mothers of reactive co-sleeping children if they decide to separate the child's bed or room. Further sleeping arrangement research with the infants and pre-schoolers will provide information about the nature of the solitary sleeping toddlers and the intentional co-sleeping toddler's developmental outcomes.

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APPENDIX A

KİŞİSEL BİLGİ FORMU

Aşağıda ebeveyn olarak size ve araştırma için bilgisi alınacak çocuğunuza dair kişisel sorular bulunmaktadır. Bu soruların cevapları kimlik bilgilerinizle eşleştirilmeyecek şekilde veri olarak istatistik amaçlı toplanacaktır. Sorular çalışmanın anlamlı sonuçlara ulaşması amacıyla sorulmaktadır, bu nedenle bu sorulara mümkün olduğunca samimi ve bildiğiniz kadarıyla tam ve doğru şekilde cevap verilmesi araştırma için önem arz etmektedir. Bu soruların sorulma mantıkları hakkında aklınıza takılan soru işaretleri olursa, araştırmacıya ulaşabilirsiniz.

Araştırmacı iletişim bilgileri:

Hande Burcu Şimşek, İstanbul Bilgi Üniversitesi Sosyal Bilimler Enstitüsü Klinik Psikoloji Yüksek Lisans Öğrencisi

A. DEMOGRAFİK BİLGİLER

1. Ebeveynin çocuğa yakınlık derecesi:
   Anne___ Baba____

2. Çocuğunuz, öz___ üvey___ evlat edinilmiş___

3. Çocuğun yaşı (lütfen ay cinsinden yazınız):

4. Çocuğun cinsiyeti:
   Kız___ Erkek__ Diğer___
   5. Yaşınız_____
5. Yaşadığınız yer:
   İl__
   İlçe__
   Kasaba__
   Köy__
   (İl merkezi ise ili (Örnek: İstanbul), ilçe ise ilçeyi (Örnek: Çorlu) yazınız. İl merkezi veya ilçe değilse, köy/kasaba/mahalle adını yazınız. (Örnek: Dereköy Köyü).
   _____

6. Medeni durumunuz:
   Çocuğun diğer ebeveyni ile evli / birlikte yaşıyor__
   Boşanmış__
   Bekar__
   Yeniden evlenmiş__

7. Kaç çocuğunuz var?
   1__ 2___ 3___ 4___ 5+___ (lütfen sayısını yazınız)

8. Araştırma için bilgisini aldığımız, yaşı 18-48 ay arası olan çocuğunuzun kardeşlerinin yaşlarını lütfen yazınız.

9. Anne eğitim durumu:
   İlkokul mezunu__
   Ortaokul mezunu__
   Lise mezunu__
   Üniversite mezunu___
   Yüksek lisans / doktora mezunu___

10. Baba eğitim durumu:
    İlkokul mezunu__
    Ortaokul mezunu__
    Lise mezunu___
    Üniversite mezunu__
    Yüksek lisans / doktora mezunu___

11. Anne çalışıyor mu
    Evet___ Hayır___ Evden çalışıyor___

12. Annenin çalışma saatleri:
    Yarı zamanlı /esnek zamanlı___
    Tam gün___
    Tam gün ve fazla mesai____

Gece veya akşam dahil olmak üzere vardiyalı____

13. Baba çalışıyor mu?
    Evet___ Hayır__ Evden çalışıyor.____

14. Babanın çalışma saatleri:
    Yarı zamanlı/esnek zamanlı_____
    Tam gün____
    Tam gün ve fazla mesai____
    Gece veya akşam dahil olmak üzere vardiyalı____

15. Hanenizin aylık geliri;
    0 – 3000 TL__
    3000 – 6000 TL__
    6000 – 9000 TL__
    9000 TL ve üzeri__

16. Evinizde sürekli olarak kimler yaşamaktadır (ikamet etmektedir):
    Anne, baba ve çocuk__
    Anne, baba, çocuk ve aile büyükleri / akrabalar_

17. Şu anda çocuğunuzun bakımını gün içinde kim(ler) üstleniyor?
    Ebeveynleri ___
    Okul öncesi kurum/kreş ____
    Bakıcı ____
    Büyükanne/büyükbaba ____
    Diğer akrabalar ____
    Komşular _____
    Ebeveynin iş yerine geliyor. ____

18. Çocuk bugüne kadar okul öncesi eğitim kurumuna /kreşe gitti mi?
    Evet__ Hayır__ Halen gidiyor___

    Aşağıdaki soruyu çocuğunuz okul öncesi eğitim kurumuna gittiyse cevaplayınız:

19. Kaç yaşında okul öncesi kuruma başladı?
    0-12 ay__ 12-18 ay___ 18-24 ay___ 24-36 ay___ 36-48 ay___ 48+ay____

B. ÇOCUĞUN GELİŞİMSEL VE GENEL SAĞLIK BİLGİLERİ

Şimdi size çocuğunuzun gelişim öyküsü ve ailenin genel sağlık durumu ile ilgili sorular soracağız.

1. Çocuğunuz;
   Vaktinde doğdu.__
   Erken doğdu.__(Lütfen doğum haftasını belirtiniz:__)
   Geç doğdu.__(Lütfen doğum haftasını belirtiniz__)

2. Çocuğunuz kaç yaşında konuştu (cümle kurma, kendini az da olsa anlatabilme seviyesinde)?
   Vaktinde (24-30 ay) __
   Erken (23.aydan önce) __
   Geç (31.aydan sonra) __
   Henüz konuşmuyor. __

3. Anne sütünden ne zaman kesildi?
   Anne sütü almadı___
   0-6 ay__ 7-12 ay___ 12-18 ay___
   18-24 ay__ 24-30 ay___ 30 ay+_____
   Sütten kesilmedi, gece ve gündüz emiyor. ____
   Sütten kesilmedi, yalnız geceleri emiyor. ____
   Sütten kesilmedi, yalnız gün içinde emiyor. ____
   Emzirilmiyor fakat biberon vb. ile gece beslenmesi devam ediyor. ____

4. Çocuğunuzun tanısı konulmuş veya tanı konulmasa da destek alınması söylenilmiş herhangi bir gelişimsel problemi var mı ?
   Evet_____ (Lütfen belirtiniz :_____)
   Hayır_____

5. Çocuğunuzun herhangi bir kronik hastalığı var mı?

Evet___ (Lütfen belirtiniz:_____)

Hayır_ __

6. Çocuğunuzun herhangi bir kronik hastalığı var mı?

   Evet___ (Lütfen belirtiniz:_____)

   Hayır___

7. Çocuğunuz bir hastalık, kaza, travma, hastanede yatma, ameliyat geçirdi mi?

   Evet_____ (Lütfen belirtiniz:_____)

   Hayır_____

8. Ailenizde kronik rahatsızlık mevcut mu?

   Evet__(Lütfen hastalığı ve kimde görüldüğünü belirtiniz:_____)

   Hayır__

9. Aile üyelerinizde herhangi bir psikiyatrik tanı mevcut mu?

   Evet___ (Lütfen tanıyı ve kimde görüldüğünü belirtiniz:_____)

   Hayır____

APPENDIX B

UYKU ALIŞKANLIKLARI ANKETİ

Şimdi size çocuğunuzun uyku alışkanlıkları ve sizin bu alışkanlıklarla ilgili tutumlarınız ile ilgili çeşitli sorular soracağız.

a. Çocuğunuzun Uyuduğu Yer

1. Çocuğunuzun odası var mı?
   Kendine ait odası var__ Kardeş(ler)iyle beraber odası var___ Odası yok__

2. Çocuğunuz geceleri nerede uyur ? Son bir ay için cevaplayınız.
   Tüm gece kendi odasında uyur. ___
   Tüm gece ebeveyn yatağında uyur. ___
   Tüm gece kardeşleriyle birlikte odasında uyur. ___
   Tüm gece ebeveyn yatak odasında fakat ayrı bir yatak/beşikte uyur. ___
   Kendi yatağında uyusa da, gecenin en az yarısında ebeveyn ile birlikte uyur. ___
   Ebeveynle birlikte uyuduğu zamanlar olsa da, gecenin çoğunluğunda kendi yatağında uyur. __

3. Çocuğunuz ne sıklıkla ebeveyn(ler)iyle birlikte uyur ?
   Haftada her gün __
   Haftada 1-2 gece __
   Haftada 3-4 gece __
   Haftada 5-6 gece __
   Hiçbir zaman __
   Yılda birkaç defa __

4. Çocuğunuzun kendi odasında uyuduğu bir dönem oldu mu ?
   Evet__
   Hayır__

5. Çocuğunuz ilk olarak ne zaman ayrı bir odada (yalnız ya da kardeşleri ile) uyumaya başladı ? (Şu anda ayrı odada uyumuyor olsa bile, ilk uyuduğu zamanı işaretleyiniz.)
   0-12 ay__
   12-18 ay__
   18-24 ay__
   2 yaş __
   3 yaş ve sonrası __
   Hiç yalnız uyumadı. __

6. Çocuğunuz ne zaman ebeveyn yatak odasında uyumaya başladı ?
   Nadir durumlar hariç ebeveyn yatak odasında uyumaz. __
   Doğduğundan beri ebeveyn yatak odasında uyuyor. __
   1 yaşından önce kendi odasından ebeveyn odasına geri geçti. __
   1 yaşından sonra ebeveyn odasına geçti. ___ (Lütfen yaşını belirtiniz :_____)

7. Partneriniz genellikle geceleri nerede uyur ?
   Ebeveyn yatak odasında__
   Gecenin bir kısmında ebeveyn yatak odasında, bir kısmında ayrı bir odada__
   Tüm gece ayrı odada__
   Uygun Değil ___

8. Çocuğunuz şu anda sizin en çok tercih ettiğiniz yerde mi uyuyor ?
   Evet__
   Hayır__

9. Çocuğunuzun şu an uyuduğu yerden memnun musunuz? 1 ile 5 arasında puanlayınız.

1	2	3	4	5
Hiç memnun Değilim.		Biraz memnunum.		Tamamen memnunum.

.

10. Çocuğunuzun uyuduğu yer ile ilgili olarak diğer insanlardan (aile, arkadaş, uzmanlar gibi) ne kadar eleştiri alıyorsunuz? 1 ve 5 arasında puanlayınız.

1	2	3	4	5
Hiç eleştirilmiyorum.		Biraz eleştiriliyorum.		Çok eleştiriliyorum.

b. Gelişimsel Uyku Alışkanlıkları

11. Bebeklikte, ilk aylarda uyku problem oldu mu?
    Kolay uyurdu, problem yoktu. ___
    Uykuya zor geçerdi fakat uzun süre uyurdu. __
    Uykuya zor geçer, sık uyanırdı. __
    Sağlık problemlerinden dolayı uyku problemi yaşardı. __

12. Çocuğunuz, ne zaman gece boyu kesintisiz uyumaya başladı (atak dönemleri, diş çıkarma dönemleri, hastalık durumları hariç)?
    6-9 ay__
    9-12 ay__
    12-18 ay__
    18-24 ay__
    24-30 ay__
    30-36 ay__
    3 yaşından sonra__
    Geceleri uyanır. __

13. Bebeklik döneminde uyku eğitimi verildi mi?
    Evet__
    Hayır__

14. Çocuğunuz şu anda geceleri ne sıklıkla uyanır?

Nadiren (haftada 0-1 kez)	Bazen (haftada 2-5kez)	Genellikle (haftada 5-7 kez)

Bir kez uyanır.	___	___	___
Birden fazla kez uyanır.	___	___	___

15. Çocuğunuz geceleri uyandığında ne kadar süre uyanık kalır?

Geceleri uyanmaz. __

1-5 dk kadar uyanık kalır. __

5 – 15 dk kadar uyanık kalır. __

15 -30 dk kadar uyanık kalır. __

30 dk ve daha fazla uyanık kalır. __

16. Çocuğunuz geceleri uyandığında aşağıdakilerin hangisini ne sıklıkla yaparsınız? 1'den 5'e puanlayınız. (1: hiç yapmam; 2: nadiren yaparım; 3:bazen yaparım; 4:sık sık yaparım; 5:her zaman yaparım)

Onu emziririm__	1 2 3 4 5
Onu beslerim__	1 2 3 4 5
Kucağıma alır / sarılır sakinleştiririm__	1 2 3 4 5
Ona sevdiği bir nesne (oyuncak, battaniye vb.) veririm__	1 2 3 4 5
Emzik veririm__	1 2 3 4 5
Sarılmadan/kucağıma almadan konuşurum/ninni söylerim__	1 2 3 4 5
Kendi yatağıma alırım__	1 2 3 4 5
Onunla birlikte çocuğumun yatağında uyurum__	1 2 3 4 5
Kendi kendine tekrar uyumasını beklerim__	1 2 3 4 5
Odama gelir, odasına gidip uyumasını söylerim__	1 2 3 4 5
Odama gelir, odasına götürüp uyumasını söylerim__	1 2 3 4 5

17. Partneriniz geceleri uyanan çocuğunuzu sakinleştirmekte rol alır mı?

1	2	3	4	5
Hiç rol almaz.		Bazen rol alır.		Her zaman rol alır.

18. Çocuğunuzun gece uyanmaları sizin uykusuz hissetmenize neden oluyor mu?

1	2	3	4	5
Hiç olmuyor.		Biraz oluyor.		Çok oluyor.

19. Çocuğunuzun gece uyanmaları şu anda sizin için bir problem mi?

1	2	3	4	5
Problem değil.		Bazen bir problem.		Kesinlikle bir problem

c. Uykuya geçme – Yatma zamanı

20. Sevdiği, uyurken veya gün içerisinde yanında taşıdığı bir eşyası (oyuncak, kumaş vb.) var mı?
    Var (oyuncak, battaniye vb)___
    Eskiden vardı, şu an yok__
    Hiçbir zaman olmadı___

21. Çocuğunuz uykuya geçerken;
    Biberonla beslenir__
    Emzik kullanır__
    Anne veya babasının saçıyla, koluyla vb. oynayarak uykuya geçer__
    Emzirilirken uyur__
    Hiçbiri__

22. Çocuğunuz yatma zamanı geldiğinde, ne sıklıkla aşağıdaki tepkileri vermektedir? (1: hiç; 2: nadiren; 3:bazen; 4:sık sık; 5:her zaman)

Kolayca uyur__	1	2	3	4	5
20-30 dk masal okuma, masaj yapma vb. rutini vardır__	1	2	3	4	5
Çok direnir, ağlar, sinirlenir__	1	2	3	4	5

23. Çocuğunuz uykuya nasıl geçer?
    Yatakta kendi başına yatarak uyuyabilir__
    Uyurken yanına anne veya babasının uzanmasına ihtiyaç duyar__
    Yatakta kendi başına uyur fakat uyuyana kadar anne ve babası aynı odada oturur__

Anne ve babasının yatağında/salonda uyur, yatağına uykusunda taşınarak gider__
Kucakta/ arabada/ gezerek uyur __
Ayakta sallanarak uyur__

24. Çocuğunuzun uykuya geçmede yaşadığı zorluklar sizin için bir problem oluşturuyor mu?

1	2	3	4	5
Problem oluşturmuyor.		Bazen problem oluşturuyor.		Her zaman problem oluşturuyor.

APPENDIX C

Ebeveyn Uyku Tutumu Ölçeği (Parental Sleep Attitude Scale – PSAS)

Çocukların Uyuduğu Yer ile İlgili Düşünceleriniz…

Bu bölüm iki kısımdan oluşmaktadır. Burada size, çocukların uyudukları yer ile ilgili birçok konuya ilişkin fikirlerinizi soruyor olacağız.. Birçok ebeveynin bu konuda çok farklı fikirleri olduğunu, burada doğru ya da yanlış yanıtlar olmadığını ve yalnızca sizin gerçek fikrinizle ilgilendiğimizi lütfen unutmayın.

BİRİNCİ KISIM Lütfen, ***kendi odasında uyuyan çocuklar*** ile ilgili olan her bir ifadeye ne derece katılıp katılmadığınızı, ifadeye karşılık gelen sayıyı seçerek (işaretleyerek) belirtin (1-6).

Kesinlikle katılmıyorum	Katılmıyorum	Kısmen Katılmıyorum	Kısmen Katılıyorum	Katılıyorum	Kesinlik katılıyor
1	2	3	4	5	6

1. Ebeveynler, çocuklarının gece boyunca kendi başlarına uyumaları için çabalar çünkü elverişli olan budur

1 2 3 4 5 6

2. Çocukların uykuya dalana kadar kendi kendilerine ağlamalarını dinlemek zorunda olmak, ebeveynlere çok kötü hissettirir

1 2 3 4 5 6

3. 6 aylık bebekleri tek başlarına uyutmak, onların bağımsızlıklarını teşvik etmek için çok iyi bir yoldur.

1 2 3 4 5 6

4. Gece ağlarlarsa ve ebeveynler buna yanıt vermezse, çocuklar ebeveynlerine olan güvenlerini kaybederler.

1 2 3 4 5 6

5. Tek başlarına uyumak, 6 aylık bebeklerin güven duygusunu azaltır.

1 2 3 4 5 6

6. Düzenli şekilde uykuya ağlayarak dalmak zorunda olan 6 aylık bebekler ihmal ediliyordur.

1 2 3 4 5 6

7. 6 aylıktan küçük bebekler, tüm geceyi uyuyarak geçirmeye gelişimsel olarak henüz hazır olmayabilirler.

1 2 3 4 5 6

8. Yatma vaktindeki mücadelelerinden anlaşıldığı üzere, çocuklar tek başlarına uyumakta zorlanırlar.

1 2 3 4 5 6

İKİNCİ KISIM Lütfen, ***ebeveynleri ile aynı yatağı paylaşan çocuklar*** ile ilgili olan her bir ifadeye ne derece katılıp katılmadığınızı, ifadeye karşılık gelen sayıyı seçerek (işaretleyerek) belirtin (1-6).

1. Yatağı paylaşmak, bir çiftin yakınlık ve mahremiyet deneyimlemesinin önüne geçer.

1 2 3 4 5 6

2. Yatağı paylaşmak, ebeveynlerin iyi bir gece uykusu uyumasının önüne geçer.

1 2 3 4 5 6

3. Yatağı paylaşmak, bir çocuğun ihtiyaçlarını karşılamak için çok iyi bir yoldur.

1 2 3 4 5 6

4. Yatağı paylaşmak, eğer çok uzun süre devam ederse, bozulması zor olan bir alışkanlıktır.

1 2 3 4 5 6

5. 2 yaşından küçük çocuklarla aynı yatağı paylaşmak, fiziksel açıdan onlar için güvenli değildir (örn. yanlışlıkla boğulabilirler, yuvarlanabilirler ya da emekleyerek yataktan düşebilirler).

1 2 3 4 5 6

6. Yatağı paylaşmak, ebeveynler ve çocuk arasındaki yakınlığın gelişmesine yardımcı olur.

1 2 3 4 5 6

7. Yatağı paylaşmak, ebeveynler arasındaki yakınlaşmaya tanık olurlarsa 6 aylık bebekler için zararlıdır.

1 2 3 4 5 6

8. Ebeveynlerinin yatağında uyuyan çocuklar, kendi odalarında uyumaya geçiş yaparken zorlanırlar.

1 2 3 4 5 6

APPENDIX D

Yakın İlişkilerde Yaşantılar Envanteri-II (Experiences in Close Relationships-Revised)

Aşağıdaki maddeler romantik ilişkilerinizde hissettiğiniz duygularla ilgilidir. Maddelerde sözü geçen "birlikte olduğum kişi" ifadesi ile romantik ilişkide bulunduğunuz kişi kastedilmektedir. Eğer hâlihazırda bir romantik ilişki içerisinde değilseniz, aşağıdaki maddeleri bir ilişki içinde olduğunuzu varsayarak cevaplandırınız. Her bir maddenin ilişkilerinizdeki duygu ve düşüncelerinizi ne oranda yansıttığını karşılarındaki 7 aralıklı ölçek üzerinde, ilgili rakam üzerine çarpı (X) koyarak gösteriniz.

1 2 3 4 5 6 7

Hiç katılmıyorum Kararsızım /fikrim yok Tamamen katılıyorum.

1. Birlikte olduğum kişinin sevgisini kaybetmekten korkarım	1	2	3	4	5	6	7
2. Gerçekte ne hissettiğimi birlikte olduğum kişiye göstermemeyi tercih ederim.	1	2	3	4	5	6	7
3. Sıklıkla, birlikte olduğum kişinin artık benimle olmak istemeyeceği korkusuna kapılırım.	1	2	3	4	5	6	7
4. Özel duygu ve düşüncelerimi birlikte olduğum kişiyle paylaşmak konusunda kendimi rahat hissederim	1	2	3	4	5	6	7
5. Sıklıkla, birlikte olduğum kişinin beni gerçekten sevmediği kaygısına kapılırım.	1	2	3	4	5	6	7
6. Romantik ilişkide olduğum kişilere güvenip dayanmak konusunda kendimi rahat bırakmakta zorlanırım.	1	2	3	4	5	6	7
7. Romantik ilişkide olduğum kişilerin beni, benim onları önemsediğim kadar önemsemeyeceklerinden endişe duyarım.	1	2	3	4	5	6	7
8. Romantik ilişkide olduğum kişilere yakın olma konusunda çok rahatımdır	1	2	3	4	5	6	7

9. Sıklıkla, birlikte olduğum kişinin bana duyduğu hislerin benim ona duyduğum hisler kadar güçlü olmasını isterim.	1	2	3	4	5	6	7
10. Romantik ilişkide olduğum kişilere açılma konusunda kendimi rahat hissetmem.	1	2	3	4	5	6	7
11. İlişkilerimi kafama çok takarım.	1	2	3	4	5	6	7
12. Romantik ilişkide olduğum kişilere fazla yakın olmamayı tercih ederim.	1	2	3	4	5	6	7
13. Benden uzakta olduğunda, birlikte olduğum kişinin başka birine ilgi duyabileceği korkusuna kapılırım.	1	2	3	4	5	6	7
14. Romantik ilişkide olduğum kişi benimle çok yakın olmak istediğinde rahatsızlık duyarım.	1	2	3	4	5	6	7
15. Romantik ilişkide olduğum kişilere duygularımı gösterdiğimde, onların benim için aynı şeyleri hissetmeyeceğinden korkarım	1	2	3	4	5	6	7
16. Birlikte olduğum kişiyle kolayca yakınlaşabilirim	1	2	3	4	5	6	7
17. Birlikte olduğum kişinin beni terk edeceğinden pek endişe duymam.	1	2	3	4	5	6	7
18. Birlikte olduğum kişiyle yakınlaşmak bana zor gelmez.	1	2	3	4	5	6	7
19. Romantik ilişkide olduğum kişi kendimden şüphe etmeme neden olur.	1	2	3	4	5	6	7
20. Genellikle, birlikte olduğum kişiyle sorunlarımı ve kaygılarımı tartışırım	1	2	3	4	5	6	7
21. Terk edilmekten pek korkmam	1	2	3	4	5	6	7
22. Zor zamanlarımda, romantik ilişkide olduğum kişiden yardım istemek bana iyi gelir.	1	2	3	4	5	6	7
23. Birlikte olduğum kişinin, bana benim istediğim kadar yakınlaşmak istemediğini düşünürüm.	1	2	3	4	5	6	7

24. Birlikte olduğum kişiye hemen hemen her şeyi anlatırım.	1	2	3	4	5	6	7
25. Romantik ilişkide olduğum kişiler bazen bana olan duygularını sebepsiz yere değiştirirler.	1	2	3	4	5	6	7
26. Başımdan geçenleri birlikte olduğum kişiyle konuşurum.	1	2	3	4	5	6	7
27. Çok yakın olma arzum bazen insanları korkutup uzaklaştırır.	1	2	3	4	5	6	7
28. Birlikte olduğum kişiler benimle çok yakınlaştığında gergin hissederim.	1	2	3	4	5	6	7
29. Romantik ilişkide olduğum bir kişi beni yakından tanıdıkça, "gerçek ben" den hoşlanmayacağından korkarım.	1	2	3	4	5	6	7
30. Romantik ilişkide olduğum kişilere güvenip dayanma konusunda rahatımdır.	1	2	3	4	5	6	7
31. Birlikte olduğum kişiden ihtiyaç duyduğum şefkat ve desteği görememek beni öfkelendirir.	1	2	3	4	5	6	7
32. Romantik ilişkide olduğum kişiye güvenip dayanmak benim için kolaydır.	1	2	3	4	5	6	7
33. Başka insanlara denk olamamaktan endişe duyarım	1	2	3	4	5	6	7
34. Birlikte olduğum kişiye şefkat göstermek benim için kolaydır.	1	2	3	4	5	6	7
35. Birlikte olduğum kişi beni sadece kızgın olduğumda önemser.	1	2	3	4	5	6	7
36. Birlikte olduğum kişi beni ve ihtiyaçlarımı gerçekten anlar.	1	2	3	4	5	6	7

APPENDIX E

Durumluk ve Sürekli Kaygı Ölçeği (STAI)

YÖNERGE:Aşağıda kişilerin kendilerine ait duygularını anlatmada kullandıkları bir takım ifadeler verilmiştir. Her ifadeyi okuyun, sonra da o anda nasıl hissettiğinizi ifadelerin şağ tarafındaki parantezlerden uygun olanını işaretlemek suretiyle belirtin. Doğru ya da yanlış cevap yoktur. Herhangi bir ifadenin üzerinde fazla zaman sarfetmeksizin anında nasıl hissettiğinizi gösteren cevabı işaretleyin.

		HİÇ	BİRAZ	ÇOK	TAMAMİYLE
1.	Şu anda sakinim	(1)	(2)	(3)	(4)
2.	Kendimi emniyette hissediyorum	(1)	(2)	(3)	(4)
3	Su anda sinirlerim gergin	(1)	(2)	(3)	(4)
4	Pişmanlık duygusu içindeyim	(1)	(2)	(3)	(4)
5.	Şu anda huzur içindeyim	(1)	(2)	(3)	(4)
6	Şu anda hiç keyfim yok	(1)	(2)	(3)	(4)
7	Başıma geleceklerden endişe ediyorum	(1)	(2)	(3)	(4)
8.	Kendimi dinlenmiş hissediyorum	(1)	(2)	(3)	(4)
9	Şu anda kaygılıyım	(1)	(2)	(3)	(4)
10.	Kendimi rahat hissediyorum	(1)	(2)	(3)	(4)

11.	Kendime güvenim var	(1)	(2)	(3)	(4)
12	Şu anda asabım bozuk	(1)	(2)	(3)	(4)
13	Çok sinirliyim	(1)	(2)	(3)	(4)
14	Sinirlerimin çok gergin olduğunu hissediyorum	(1)	(2)	(3)	(4)
15.	Kendimi rahatlamış hissediyorum	(1)	(2)	(3)	(4)
16.	Şu anda halimden memnunum	(1)	(2)	(3)	(4)
17	Şu anda endişeliyim	(1)	(2)	(3)	(4)
18	Heyecandan kendimi şaşkına dönmüş hissediyorum	(1)	(2)	(3)	(4)
19.	Şu anda sevinçliyim	(1)	(2)	(3)	(4)
20.	Şu anda keyfim yerinde.	(1)	(2)	(3)	(4)

		Hemen hemen hiçbir zaman	Bazen	Çok zaman	Hemen her zaman
21.	Genellikle keyfim yerindedir	(1)	(2)	(3)	(4)
22	Genellikle çabuk yorulurum	(1)	(2)	(3)	(4)
23	Genellikle kolay ağlarım	(1)	(2)	(3)	(4)
24	Başkaları kadar mutlu olmak isterim	(1)	(2)	(3)	(4)
25	Çabuk karar veremediğim için fırsatları kaçırırım	(1)	(2)	(3)	(4)
26.	Kendimi dinlenmiş hissediyorum	(1)	(2)	(3)	(4)
27.	Genellikle sakin, kendine hakim ve soğukkanlıyım	(1)	(2)	(3)	(4)
28	Güçlüklerin yenemeyeceğim kadar biriktiğini hissederim	(1)	(2)	(3)	(4)
29	Önemsiz şeyler hakkında endişelenirim	(1)	(2)	(3)	(4)
30.	Genellikle mutluyum	(1)	(2)	(3)	(4)
31	Herşeyi ciddiye alır ve endişelenirim	(1)	(2)	(3)	(4)
32	Genellikle kendime güvenim yoktur	(1)	(2)	(3)	(4)
33.	Genellikle kendimi emniyette hissederim	(1)	(2)	(3)	(4)
34	Sıkıntılı ve güç durumlarla karşılaşmaktan kaçınırım	(1)	(2)	(3)	(4)
35	Genellikle kendimi hüzünlü hissederim	(1)	(2)	(3)	(4)
36.	Genellikle hayatımdan memnunum	(1)	(2)	(3)	(4)
37	Olur olmaz düşünceler beni rahatsız eder	(1)	(2)	(3)	(4)
38	Hayal kırıklıklarını öylesine ciddiye alırım ki hiç unutamam	(1)	(2)	(3)	(4)
39.	Aklı başında ve kararlı bir insanım	(1)	(2)	(3)	(4)
40	Son zamanlarda kafama takılan konular beni tedirgin ediyor	(1)	(2)	(3)	(4)

APPENDIX F

Erken Çocukluk Davranış Anketi (ECBQ-Short Form)

Katılımcı No. _____

Bugünün Tarihi: Ay:____ Gün:____ Yıl:____ Çocuğun yaşı: _____Yıl, _____Ay

Çocukla akrabalık bağınız: _____Çocuğun cinsiyeti (birini işaretleyiniz): Erkek Kız

TALİMATLAR: Lütfen başlamadan önce dikkatlice okuyunuz.
Aşağıdaki çocuk davranışlarının her birini okuduktan sonra, lütfen sağ taraftaki sayılardan birini yuvarlak içine alarak çocuğunuzun son iki hafta içerisinde bu davranışları ne sıklıkla sergilediğini belirtiniz. Aşağıdaki sayılar söz konusu davranışı son iki hafta içinde ne sıklıkla gözlemlediğinizi belirtmektedir.

	çok					neredeyse
hiç	nadir	bazen	genellikle	sık sık	her zaman	her zaman
1	2	3	4	5	6	7

Uyku zamanı geldiği söylendiğinde, çocuğunuz ne sıklıkla

1. hırçınlaştı?

1 2 3 4 5 6 7

Günlük aktiviteler sırasında, çocuğunuz ne sıklıkla

2. çalışan ya da çalışmaya başlayan klima, ısıtıcı ya da buzdolabı sesi gibi pes sesleri fark etti?

1 2 3 4 5 6 7

Dışarıda diğer çocuklarla birlikte oynarken, çocuğunuz ne sıklıkla

3. en aktif çocuklardan biri gibi göründü?

1 2 3 4 5 6 7

Bir görevi tamamlamakta sorun yaşadığında (örneğin, çizmek, giyinmek), çocuğunuz ne sıklıkla

4. çabucak sinirlendi?

1 2 3 4 5 6 7

Evdeyken, çocuğunuz ne sıklıkla

5. gürültülü bir sesten (blender, elektrikli süpürge, vs.) korktu?

1 2 3 4 5 6 7

6. karanlıktan korkuyormuş gibi göründü?

1 2 3 4 5 6 7

Banyo yaparken, çocuğunuz ne sıklıkla

7. sessizce oturdu?

1 2 3 4 5 6 7

Üzgün olduğunda, çocuğunuz ne sıklıkla

8. kolayca sakinleşti?

1 2 3 4 5 6 7

Günlük aktiviteler sırasında, çocuğunuz ne sıklıkla

9. bir yerden başka bir yere hızlı bir şekilde geçti?

1 2 3 4 5 6 7

10. bir malzemenin (materyalin) çok yumuşak (pamuk) ya da sert (yün) olduğunu fark etti

1 2 3 4 5 6 7

11. hiçbir neden olmadan korkuyormuş gibi göründü?

1 2 3 4 5 6 7

Halka açık bir yerdeyken, çocuğunuz ne sıklıkla

12. bir asansöre yaklaşmakla ilgili tedirginlik sergiledi?

1 2 3 4 5 6 7

13. tanımadığı bir hayvan yanına yaklaştığında tedirgin oldu ya da ağladı?

1 2 3 4 5 6 7

14. büyük ve gürültülü vasıtalardan korkmuş gibi göründü?

1 2 3 4 5 6 7

15. kendisine bakan kişi gözden kaybolduğunda korkmuş gibi davrandı?

1 2 3 4 5 6 7

Çocuğunuzun elbiselerini giydirirken ya da çıkarırken, çocuğunuz ne sıklıkla

16. sıyrılıp kaçmaya çalıştı? 1 2 3 4 5 6 7

17. sakince durdu? 1 2 3 4 5 6 7

Heyecanlı bir aktivite ya da olaydan sonra, çocuğunuz ne sıklıkla

18. çabucak sakinleşti? 1 2 3 4 5 6 7

19. sakinleşmekte sıkıntı yaşadı? 1 2 3 4 5 6 7

Gündelik aktiviteler-işler sırasında, çocuğunuz ne sıklıkla

20. (ıslak saç, şapka ya da takı gibi) görünüşünüzdeki değişiklikleri fark etti?

1 2 3 4 5 6 7

21. çok alçak sesleri bile dinliyormuş gibi göründü?

1 2 3 4 5 6 7

22. akşam saatlerinde bile, enerji dolu göründü?

1 2 3 4 5 6 7

İç mekanda oynarken, çocuğunuz ne sıklıkla

23. evin içinde koşuşturdu? 1 2 3 4 5 6 7

24. mobilyaların üzerine tırmandı? 1 2 3 4 5 6 7

Bir şey istediğinde ve siz "hayır" dediğinizde, çocuğunuz ne sıklıkla

25. kızdı? 1 2 3 4 5 6 7

26. öfkeyle sitem etti? 1 2 3 4 5 6 7

27. öfke krizi geçirdi? 1 2 3 4 5 6 7

Dışarıda yürürken ya da oynarken, çocuğunuz ne sıklıkla

28. görüntüleri ya da sesleri fark etti (örneğin, rüzgar çanları ya da su fıskiyeleri gibi)?

1 2 3 4 5 6 7

Yeni bir yeri ziyaret ettiğinizde, çocuğunuz ne sıklıkla

29. girmek istemedi?

1 2 3 4 5 6 7

Davranışlarını tatlılıkla eleştirdiğinizde ya da düzelttiğinizde, çocuğunuz ne sıklıkla

30. öfkelendi?

1 2 3 4 5 6 7

Üzüldüğünde, çocuğunuz ne sıklıkla

31. rahatlatmaya çalışmanıza rağmen, 3 dakikadan daha fazla bir süre boyunca ağladı?

1 2 3 4 5 6 7

32. kolayca sakinleşti?

1 2 3 4 5 6 7

APPENDIX G

KATILIMCI BİLGİ VE ONAM FORMU

İstanbul Bilgi Üniversitesi Sosyal Bilimler Enstitüsü

Gönüllü katılımcı onay formunu okuyor olduğunuz bu bilimsel çalışma, Dr. Öğr. Üyesi Elif Akdağ Göçek danışmanlığında, İstanbul Bilgi Üniversitesi Sosyal Bilimler Enstitüsü Klinik Psikoloji programı Çocuk-Ergen Altdalı öğrencisi Hande Burcu Şimşek tarafından bitirme tezi kapsamında yürütülmektedir.

Araştırmanın amacı, Türkiye'de yaşayan küçük çocukların uyudukları yer ile ilişkili psikolojik etmenleri incelemektir.

Araştırma için sizden istenen, size iletilecek formlardaki soruları okuyarak, kimsenin baskısı altında olmadan size en doğru veya uygun gelen şekilde cevaplamanızdır. Araştırma sorularının sizde psikolojik sağlığa dair herhangi bir risk oluşturması beklenmemektedir. Araştırmadaki soruları cevaplamak 20 dk sürmektedir.

Bu çalışmaya katılmak, tamamıyla gönüllülük esasına dayanmaktadır. Herhangi bir kimlik bilgisi alınmayacaktır Araştırmaya katılmanız halinde, cevapladığınız kişisel bilgileriniz ile kimlikleriniz arasında bağlantı kurulmayacaktır.. Toplanan veriler sadece araştırmacılara açık olacaktır ve sadece araştırma sonuçlarına ulaşma amaçlı olarak kullanılacaktır. Cevaplarınızdan yola çıkarak oluşturulan veriler istatistiki bilgiler şeklinde bilimsel yayınlarda kullanılabilir.

Bu formu okuyup onaylamanız, araştırmaya katılmayı kabul ettiğiniz anlamına gelecektir. Ancak, çalışmaya katılmama veya katıldıktan sonra herhangi bir anda çalışmayı bırakma hakkına koşulsuz sahipsiniz. Araştırmaya dair bilgi edinmek istediğinizde araştırmacıya adresinden ulaşabilirsiniz. Araştırmaya gönüllü olarak katılmak istiyorsanız, aşağıdaki onay bölümünü doldurunuz.

İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı'nda Dr. Öğr. Üyesi Elif Akdağ Göçek gözetiminde, Hande Burcu Şimşek tarafından yürütülen bu çalışma hakkında verilen yukarıdaki bilgileri okudum. Yapılan tüm açıklamaları anlamış bulunuyorum. Araştırma sonuçlarının eğitim ve bilimsel amaçlarla kullanımı sırasında kişisel bilgilerimin korunacağı konusunda yeterli güvence verilmiştir. Bu koşullarla söz konusu araştırmaya kendi isteğimle gönüllülük kapsamında katılmayı kabul ediyorum.

Onaylıyorum___

ETHICS BOARD APPROVAL

Ethics Board Approval is available in the printed version of this dissertation.