

THE

# Sleep Training

PLAYBOOK

---

A research-backed guide to sleep training, night weaning, and finally getting some rest

**JACK HARTLEY**

Dad of Two

---

FamilyForce Publishing | [familyforce.com](https://familyforce.com)

© 2026 Jack Hartley. All rights reserved.

No part of this publication may be reproduced, distributed, or transmitted in any form or by any means, including photocopying, recording, or other electronic or mechanical methods, without the prior written permission of the publisher, except in the case of brief quotations embodied in critical reviews and certain other noncommercial uses permitted by copyright law.

**Published by FamilyForce Publishing**

[familyforce.com](http://familyforce.com)

First published 2026

# Contents

---

Chapter 1: The 133-Night Deficit	2
Chapter 2: How Babies Sleep	5
Chapter 3: Safe Sleep	9
Chapter 4: The Newborn Phase	12
Chapter 5: Choosing Your Method	15
Chapter 6: Game Night	19
Chapter 7: The Team	23
Chapter 8: The Feeding Factor	26
Chapter 9: Naps	29
Chapter 10: The Co Sleeping Question	31
Chapter 11: Regressions	34
Chapter 12: The Toddler	37
Chapter 13: After the Game	40
Appendix A: The Sleep Plan Worksheet	41
Appendix B: Quick Reference	42
Appendix C: Sources and Further Reading	44
Appendix D: Is This Normal?	45
About the Author	46

# A few disclaimers

- A note on medical advice: This book is based on published clinical studies, academic journals, pediatric guidelines, books, the author's experience, and a variety of other studies. It is not a substitute for guidance from your child's pediatrician. Every child is different. If something in this book doesn't match what you're seeing, trust your doctor over this guidebook.

- A note on individual children: This book is written for typically developing kids. If your child has ADHD, is on the autism spectrum, or has sensory processing differences, these timelines and thresholds may not fit as written. Check with your pediatrician before holding these guidelines too tightly.

- A note on pronouns: I refer to the child as "he" throughout because I have two sons. Everything in this book applies equally to daughters unless stated otherwise.

- If you are parenting solo: everything in this book applies. Where the book refers to a partner or co caregiver, substitute whoever is your primary support: a grandparent, a trusted adult, a daycare provider. The consistency principle is the same: the fewer mixed signals your child receives across caregivers, the better the outcomes.

- A note for parents of premature babies: use your baby's adjusted age throughout this book, not their birth age. The four month minimum, the wake windows, and the developmental markers all run from adjusted age, not the date on the birth certificate.

- A note on medical causes: some babies have a medical reason for disrupted sleep, reflux, food allergies, or ear infections. If your baby is in pain or discomfort, sleep training is not the right first step. Address the medical issue first. When your pediatrician is satisfied that nothing physical is driving the waking, the methods in this book apply.

# Chapter 1: The 133-Night Deficit

## FIRST SON & SECOND SON

---

My First Son did not sleep through the night until he was fourteen months old.

For over a year, he woke two, three, sometimes four times a night. We rocked him. We fed him. We bounced on a yoga ball in the dark at 3 AM like it was a reasonable thing for adults to be doing. We tried white noise. We tried no white noise. We tried driving him around the block at midnight because someone on the internet said it worked.

Nothing worked. Or rather, everything worked for twenty minutes, and then we were back in the hallway, dead eyed, holding a baby who was wide awake and furious about it.

My wife and I stopped having conversations. We spoke in logistics. Whose turn. Did he eat. I think he's teething. I am so tired I put the remote control in the refrigerator. That last one is not a joke.

I had read zero books on infant sleep. I had googled things at 2 AM, absorbed contradictory advice from strangers, and received a single sentence from our pediatrician: "Some babies just take longer." I took that as permission to keep doing what we were doing, which was rocking our son to sleep every night and then wondering why he couldn't fall back asleep on his own at 1 AM when the rocking stopped.

I did not understand, at the time, that we were the problem.

When Second Son arrived, I was not going to repeat that. I read the research. Not blogs, not forums. The actual studies. I read what the American Academy of Sleep Medicine recommends. I read the five year follow up data. I read the critics, too.

At five months, we started. Graduated extinction. Put him down awake. Left the room. Came back at intervals. Did not pick him up.

Night one was heavy crying. The kind that makes your chest tight and your hands shake. My wife and I disagreed about how long to let it go. That disagreement is its own chapter in this book, because nearly every couple has it.

Night two was shorter. Night three, shorter still. By night five, he fussed for a few minutes and fell asleep. By night seven, I put him in the crib, said good night, and walked out. Silence. He was asleep.

Same parents. Same house. The difference was that the second time, I had a plan.

## THE SCIENCE

---

Parents lose 133 nights of sleep in their baby's first year.

That number comes from a Snuz survey of 1,300 parents. Seven in ten reported losing three hours of sleep per night across the entire first year. It is commercial research, not a clinical study, but consistent with what sleep researchers have documented. Other surveys put it higher: a Silentnight study found new parents average 975 nighttime wake ups in year one. The peer reviewed literature supports the same picture. A systematic review of parental sleep studies found that mothers average fewer than six hours of sleep per night in the first four months postpartum, with significant impairment to mood and cognitive function.

Before the baby, 68 percent of adults regularly got seven or more hours. After, 10 percent.

This is not just discomfort. Sleep deprivation at this level impairs judgment and reaction time at rates comparable to alcohol intoxication. It is the strongest predictor of postpartum depression and a significant driver of the decline in marital satisfaction that most couples experience in year one. You cannot be the parent or partner you want to be on five hours of broken sleep. The math does not work.

Here is the part that matters. It does not have to be this way.

A 2006 meta analysis by Mindell and colleagues, commissioned by the American Academy of Sleep Medicine and published in *Sleep*, reviewed 52 studies on behavioral sleep interventions. Ninety four percent found them effective. A 2016 randomized trial by Gradisar, published in *Pediatrics*, found that the method helped babies fall asleep faster, lowered cortisol, and produced no differences in attachment at twelve months. A 2012 study by Price, also in *Pediatrics*, followed 326 families for five years and found zero differences in emotional health, behavior, or parent child closeness between sleep trained and control children. Zero.

The science is not ambiguous. Behavioral sleep training works and it is safe. The problem is not the evidence. The problem is that the evidence is buried in journals, while the internet is full of noise, guilt, and contradiction. Parents end up overwhelmed, confused, and doing what I did with First Son. Winging it.

This book exists because I went looking for one resource that pulled it all together. The science, the methods, the practical steps, and the honest account of what it actually feels like to do this. I could not find it. So I did the research myself, tested it with Second Son, and wrote down what I learned.

## THE LESSON

The difference between a brutal first year and a manageable one is rarely the baby. It is almost always the information the parents had going in.

## HOW TO USE THIS BOOK

---

Each chapter gives you three things. A real story from my family, with both sons. The research, in plain language. And specific things you can do.

Chapters 2 and 3 cover the science of baby sleep and the non negotiable safety rules. Read these first.

Chapter 4 covers the newborn phase. You cannot sleep train a newborn, but you can build habits that make training easier when the time comes.

Chapters 5 and 6 are the core. Chapter 5 explains every major method. Chapter 6 is the night by night plan.

Chapter 7 is about teamwork between parents, including what the research says about the specific role fathers play in infant sleep outcomes.

Chapters 8 and 9 cover feeding and naps. Chapter 10 is an honest look at cosleeping. Chapter 11 handles regressions. Chapter 12 extends into toddlerhood.

Read it before the baby arrives if you can. Read it with your partner. If you are already in the middle of sleepless nights, go directly to the chapter that matches where you are.

Let's get started.

## Chapter 2: How Babies Sleep

### FIRST SON & SECOND SON

---

When First Son was eight weeks old, I remember telling a friend: "Something is wrong with him. He won't sleep more than two hours at a time."

Nothing was wrong with him. He was a normal newborn. I just had no idea what normal looked like.

I thought babies were supposed to sleep in long stretches from the beginning and that ours was failing at it. So I did what felt logical. I tried to force longer sleep. I kept him up during the day, thinking he would be more tired at night. I rocked him harder, longer, more desperately. I interpreted every waking as a problem to solve rather than a phase to wait out.

All of it made things worse. Keeping him up longer made him overtired, which made him sleep worse, not better. Rocking him to sleep every time meant he needed rocking to fall back asleep every time he stirred. I was building habits I would spend the next year trying to undo.

With Second Son, I understood the biology before he arrived. I knew that newborns do not have a circadian rhythm. I knew that sleep cycles are short and arousals between them are normal. I knew that the brain builds its internal clock on a specific timeline that no amount of parenting can accelerate.

That knowledge did not make the newborn phase easy. It made it survivable. Because instead of fighting what was happening, I could work with it.

### THE SCIENCE

---

There are four things about infant sleep that every parent needs to understand. Together, they explain why your baby sleeps the way they do and why the strategies in this book work.

#### **Your baby has no internal clock yet.**

Adults run on a circadian rhythm, a 24-hour cycle that tells us to be awake during the day and asleep at night. Newborns do not have one. Their sleep is scattered randomly across the full 24 hours because the brain structures responsible for day night regulation are not yet developed.

The clock gets built on a predictable schedule. Around six to eight weeks, cortisol rhythms begin to emerge and the brain starts to prefer an earlier bedtime. Around nine weeks, the body begins producing melatonin, the hormone that induces sleepiness in response to darkness. By eleven weeks, body temperature rhythms develop. By three to four months, sleep architecture matures into the adult like pattern of light sleep, deep sleep, and REM cycling that will persist for the rest of their life.

This timeline is not a suggestion. It is neurobiology. It is the reason every credible source says do not attempt formal sleep training before four months. The hardware is not installed yet.

**Sleep cycles are short, and arousals between them are normal.**

Adults cycle through sleep stages roughly every 90 minutes. Between cycles, we briefly stir, adjust a pillow, roll over, and fall back asleep without fully waking. We do not even remember these arousals.

Babies cycle every 45 to 60 minutes. Between every cycle, they experience a brief arousal, just like adults. The difference is what happens next.

If a baby fell asleep independently, in their crib, without being held or rocked or fed, they are likely to pass through the arousal and continue sleeping. The conditions match. Nothing has changed. They drift back under.

If a baby fell asleep being rocked in your arms, and they wake between cycles in a still, dark crib, the conditions do not match. Something is wrong. They wake fully and they cry.

This is the core insight of sleep training. The way a baby falls asleep at bedtime determines whether they can fall back asleep at 1 AM, 3 AM, and 5 AM. If they need you to fall asleep, they need you every 45 minutes. This is not a behavioral problem. It is a mismatch between the conditions of falling asleep and the conditions of staying asleep.

It is also the mistake I made with First Son for over a year.

**Overtired babies sleep worse, not better.**

This is the most counterintuitive fact in infant sleep, and it caught me completely off guard.

When a baby stays awake longer than their body can handle, the brain releases cortisol. This is a stress hormone. It is designed to keep you alert in emergencies. In a baby who has missed their sleep window, it creates a second wind. The baby becomes wired, fussy, and harder to settle. When they finally do fall asleep, the elevated cortisol leads to shorter naps, more night wakings, and earlier morning wake ups.

Dr. Marc Weissbluth, a pediatrician and sleep researcher at Northwestern, summarized this phenomenon as "sleep begets sleep." A well rested baby falls asleep more easily and stays asleep longer. A baby who has been kept awake too long does the opposite of what you would expect. They fight sleep harder and sleep less.

The practical tool for preventing this is the wake window, the amount of time a baby can comfortably stay awake between sleep periods. Wake windows vary by age and are shorter than most parents expect, especially in the first six months.

**Wake windows are a guide, not a law.**

The following ranges are based on practitioner consensus and developmental research. Individual babies vary. Use these as a starting point and adjust based on your child's cues.

Age	Awake Between Sleeps	Naps Per Day
0 to 4 weeks	30 to 60 minutes	5 to 7
4 to 12 weeks	60 to 90 minutes	4 to 5
3 to 4 months	75 minutes-2 hours	3 to 4
5 to 7 months	2 to 3 hours	3
7 to 10 months	2.5 to 3.5 hours	2
10 to 14 months	3 to 4 hours	1 to 2
14 to 24 months	4 to 6 hours	1

When your baby yawns, rubs their eyes, stares off, or loses interest in play, the window is closing. Act before it closes. Once cortisol kicks in, you are chasing a moving target.

**THE LESSON**

Your baby's sleep is governed by biology, not behavior. Understanding the circadian timeline, the sleep cycle problem, and the overtired trap will do more for your family's sleep than any single technique.

**TRY THIS**

---

1. Stop fighting the newborn schedule. If your baby is under three months, short and unpredictable sleep is normal. You are not doing anything wrong. Their clock is still being built.
2. Chapter 8 covers feeding and sleep associations in full. It is the single most important practical change in this book. Read it before you start sleep training.
3. Learn your baby's wake windows and set a timer. Do not wait for your baby to tell you they are tired. By the time they are rubbing their eyes and fussing, they are already on the edge of overtired. Watch the clock and watch the baby. When in doubt, put them down earlier.
4. Practice drowsy but awake, placing your baby down when they are sleepy but not yet fully asleep, even if it only works once out of five attempts. Every successful independent sleep onset is building a skill. It will not click overnight. It is not supposed to. You are making deposits.
5. Accept that your baby will wake between sleep cycles. This is not a failure of the method or of your child. It is how human sleep works. The question is not whether they wake. It is whether they can get themselves back to sleep without you.

# Chapter 3: Safe Sleep

## FIRST SON & SECOND SON

---

When First Son was three weeks old, I fell asleep holding him on the couch.

I did not mean to. It was 4 AM. He had been up since 2. I was feeding him a bottle, sitting upright, telling myself I would stay awake. The next thing I remember is my wife shaking my shoulder. I had slid sideways. He was wedged between my body and the couch cushion.

Nothing happened. He was fine. But the image of what could have happened stayed with me for weeks. I did not tell anyone about it for months.

I am telling you now because the most dangerous sleep decisions parents make are the ones they make at 4 AM when they are too exhausted to think clearly. The parent who swears they will never co sleep on the couch is the same parent who does it three weeks in, not because they changed their mind but because their body gave out.

This chapter exists to make sure you know the rules before you are too tired to look them up. Some of what follows is flexible. This chapter is not.

## THE SCIENCE

---

Approximately 3,500 infants die each year in the United States from sudden unexpected infant death, a category that includes SIDS, accidental suffocation, and strangulation in the sleep environment. The American Academy of Pediatrics updated its safe sleep guidelines in 2022, the first revision since 2016. The core recommendations have not changed in their direction, only in their specificity.

The guidelines reduce to three letters.

**A, Alone.** Nothing in the crib except the baby and a fitted sheet. No bumpers, blankets, stuffed animals, pillows, or positioners. Wearable blankets and sleep sacks are the alternative to loose bedding.

**B, Back.** Every sleep, every time, until the baby can roll both ways independently. Once they can roll on their own, you do not need to reposition them. But always place them on their back to start.

C, Crib. A firm, flat surface that meets current Consumer Product Safety Commission standards. A crib, a bassinet, or a play yard with a firm mattress. Not a swing, not a car seat for extended sleep, not a lounger, and not an inclined surface of any kind.

Room sharing, meaning the baby sleeps in your room on a separate surface, is recommended for at least the first six months. The AAP cites evidence that room sharing reduces SIDS risk by approximately 50 percent. This is not the same as bed sharing. The baby has their own sleep surface within arm's reach.

A few specifics that trip parents up.

Pacifiers reduce SIDS risk. Offer one at sleep times. If it falls out after the baby is asleep, you do not need to replace it.

Swaddling is appropriate for newborns who are not yet rolling. The moment your baby shows signs of rolling, transition to a sleep sack with arms free. A swaddled baby who rolls to their stomach cannot use their arms to reposition and is at significantly elevated risk.

Weighted swaddles and weighted sleep sacks were explicitly warned against in the 2022 AAP update. Do not use them.

Inclined sleepers, including products like the now recalled Rock 'n Play, are not safe for sleep. Babies should sleep on a flat surface with an incline of no more than ten degrees.

The safest crib is a boring crib. Nothing in it but a baby and a fitted sheet.

One more variable that is easy to overlook: room temperature. Overheating is an independent risk factor for SIDS. Keep the sleep environment between 68 and 72 degrees Fahrenheit (20 to 22 Celsius). A baby who is sweating, flushed, or whose chest feels hot to the touch is too warm. A sleep sack is designed to replace a blanket, it is not meant to be layered on top of heavy fleece pajamas in a warm room. When in doubt, dress the baby in one light layer and keep the room cool. If you are comfortable in short sleeves, the room is warm enough.

Tobacco smoke exposure is another variable worth naming directly. The 2022 AAP guidelines identify prenatal and postnatal secondhand smoke as independent SIDS risk factors, separate from whether a parent smokes inside the home or immediately near the baby. A household where any member smokes, even outside, carries elevated risk. The baby's sleep environment should be smoke free.

## THE LESSON

Safe sleep is not a parenting philosophy. It is not a preference. It is the baseline that everything else in this book is built on. Get this right first.

## TRY THIS

---

1. Set up the sleep space before the baby arrives. Crib or bassinet with a firm mattress and a single fitted sheet. Nothing else. Do it now so you are not making decisions about it at 2 AM.
2. Buy two or three sleep sacks in the appropriate size. They replace blankets entirely. Keep the room between 68 and 72 degrees Fahrenheit. A sleep sack on a baby in heavy pajamas in a warm room is too much. If you are comfortable in short sleeves, the room is the right temperature.
3. Put the crib or bassinet in your room for the first six months. It does not need to be permanent. It needs to be close.
4. Talk to your partner about what happens when you are exhausted and the baby will not settle. Have a plan for that moment before it arrives. Shifts, a safe sleep surface in every room, a rule that if you feel yourself falling asleep holding the baby, you put them down first. The couch is never the answer.
5. Remove the extras from the crib. The cute bumpers. The decorative blanket from the baby shower. The stuffed animal that matches the nursery theme. All of it comes out. You can put it back when they are older. For now, bare is safe.

## Chapter 4: The Newborn Phase

### FIRST SON & SECOND SON

---

The first six weeks with First Son were chaos that I mistook for a problem. I thought we were doing something wrong. I thought if I could just find the right trick, the right swaddle, the right sound machine setting, he would sleep in long predictable stretches.

He would not, because he could not. His brain did not have a circadian rhythm yet. He was sleeping in scattered chunks across the full 24 hours because that is what newborn brains do. I was trying to impose order on biology that was not ready for order.

What I should have been doing was surviving the chaos while quietly building habits that would pay off later.

With Second Son, that is exactly what I did. I did not try to sleep train him. I did not try to put him on a schedule. I focused on three things: a consistent bedtime routine starting at six weeks, brief attempts at drowsy but awake even when they failed, and protecting my wife's and my own sleep through shifts.

The shifts saved us. From the beginning, I took 8 PM to 1 AM. She took 1 AM to 6 AM. During your shift, you handled everything. During your off shift, you slept in another room with earplugs in. It was not romantic. It was functional. We each got a five hour block of uninterrupted sleep every night, which is enough to stay sane.

By the time Second Son was four months old, he had a bedtime routine he recognized, some experience falling asleep without being held, and two parents who were tired but not broken. That foundation made everything in Chapters 5 and 6 possible.

### THE SCIENCE

---

The newborn phase runs from birth to approximately four months. During this period, formal sleep training is not appropriate because the neurological systems it depends on are still developing. But the habits you build now have a direct effect on what happens later.

A 2009 study by Mindell and colleagues, published in *Sleep*, examined bedtime routines in over 10,000 children across 14 countries. Children with a consistent nightly routine had earlier bedtimes, shorter sleep onset latency, longer sleep duration, and fewer night wakings. The effect was significant regardless of culture, and it was detectable in infants as young as seven months. The routine itself mattered less than the consistency.

Start one by six weeks. It does not need to be elaborate. Bath, pajamas, feed, book, song, crib. Fifteen to twenty minutes. The same order every night. The routine is a signal. Over time, the baby's brain begins to associate this sequence with the onset of sleep.

The other habit worth building is drowsy but awake. This means putting the baby down when they are sleepy but not fully asleep, giving them a chance to experience the sensation of falling asleep in the crib rather than in your arms. In practice, you are looking for: heavy eyelids fighting to stay open, body movements slowing and becoming less purposeful, a glazed or unfocused gaze, and reduced responsiveness to your voice. They may still be making small sounds or moving their mouth. When they blink slowly and their body begins to go soft but their eyes are still open, that is the window. It is narrow, especially in the early weeks, and you will miss it sometimes. That is fine. You are introducing the concept, not perfecting it.

This will not work reliably at this age. That is fine. You are not trying to succeed every time. You are introducing the concept. If your baby falls asleep independently once out of five attempts, that is meaningful. Each time it happens, you are building an association between the crib and the act of falling asleep.

If it does not work at all, do not force it. Rock them, hold them, do what you need to do. The newborn phase is not the time for rigid rules. It is the time for gentle experiments.

One more thing about this period. The four month sleep regression is coming. It is not actually a regression. It is a permanent maturation of sleep architecture, from newborn style sleep to the adult style cycle of light sleep, deep sleep, and REM. This is the moment when a baby who was sleeping in three hour stretches suddenly starts waking every 45 minutes.

If your baby has been falling asleep independently, even sometimes, this transition is manageable. If they have been falling asleep exclusively with rocking, feeding, or bouncing, this is the moment the wheels come off. The new sleep architecture creates more arousals, and every arousal is a moment where the conditions mismatch matters.

The four month mark is not when sleep falls apart. It is when the skills you did or did not build in the first four months become visible.

#### THE LESSON

You cannot sleep train a newborn. But the newborn phase is not a waiting room. It is a foundation. What you do in the first four months determines how hard or easy the next step will be.

#### TRY THIS

---

1. Start a bedtime routine at six weeks. Same activities, same order, every night. Keep it under twenty minutes.
2. Take shifts with your partner. Divide the night into two blocks. During your off shift, sleep in a separate space with earplugs or white noise. Protect that block.
3. Practice drowsy but awake without pressure. Try it once a day. If it works, notice that. If it does not, move on. You are planting seeds, not harvesting.
4. Begin separating the last feed from the act of falling asleep as early as six weeks. Chapter 8 explains exactly how and why, it is the most consequential habit in the first year.
5. When the four month regression hits, do not panic. It is not a sign that something went wrong. It is a sign that the brain just upgraded. Go to Chapter 5.

# Chapter 5: Choosing Your Method

## FIRST SON & SECOND SON

---

With First Son, I did not choose a method. I had a vague sense that I was supposed to "let him cry" or "not let him cry" and I toggled between the two depending on how tired I was and how guilty I felt. Some nights I rocked him for an hour. Other nights I put him down and lasted four minutes before going back in.

The inconsistency was the problem. He was getting a different signal every night. Sometimes crying worked and I appeared. Sometimes it did not. He had no way to learn anything from that because the rules kept changing.

With Second Son, I picked graduated extinction before night one. I understood what it was, why it worked, and what the first week would look like. When night two was harder than night one, I did not panic because I knew that was normal. When my wife wanted to go in sooner, we had already agreed on the intervals. The plan held because we had made the decision in advance, not in the moment.

Choosing a method is not about finding the one true answer. It is about removing uncertainty so that when you are exhausted and your baby is crying, you know what to do next.

## THE SCIENCE

---

There are five evidence based approaches to sleep training. They sit on a spectrum from more crying and faster resolution to less crying and slower resolution. None of them is universally right. All of them work if applied consistently.

Extinction. Put the baby down awake. Leave. Do not return until morning or a scheduled feed. This is sometimes called "cry it out," though that label is misleading because every method involves some crying. Extinction has the strongest evidence base. The American Academy of Sleep Medicine classifies it as a well established treatment based on 19 studies reviewed in the Mindell meta analysis. Most babies improve within two to three nights. The crying is heaviest on night one, often 45 to 90 minutes, and drops sharply after that.

Graduated extinction (the Ferber method, by another name, "extinction" is behavioural science terminology for letting the crying reduce over time by not reinforcing it). Put the baby down awake. Leave. Return at increasing intervals, typically three minutes, then five, then ten, for brief check ins of thirty seconds or less. Do not pick the baby up. This is the Ferber method. A 2016 randomized trial by Gradisar found that the method helped babies fall asleep faster, lowered cortisol levels in treated infants, and produced no differences in attachment at twelve months. Resolution typically takes five to seven nights. This is the method I used with Second Son.

Chair method. Sit in a chair next to the crib. Offer verbal and gentle physical comfort but do not pick the baby up. Every two to three nights, move the chair farther from the crib until you are out of the room. This has moderate evidence, classified in research as extinction with parental presence. It typically takes one to two weeks. For some babies, seeing a parent they cannot reach is more frustrating than being alone. For others, the visible presence is reassuring.

Pick up, put down. When the baby cries, pick them up and soothe them. When they are calm but still awake, put them back down. Repeat. This method involves the least crying from the baby and the most exhaustion from the parent. Evidence is limited to case studies and anecdotal reports. It works best for babies under five months and can require 50 to 100 repetitions per session in the early nights.

Bedtime fading. Temporarily push bedtime later to match when the baby naturally falls asleep easily. Then gradually move bedtime earlier, fifteen minutes every two to three nights. Combined with a strong positive routine, this reduces bedtime resistance with minimal crying. Gradisar's 2016 trial tested this alongside graduated extinction and found it effective, though slightly less so for night wakings. Resolution takes two to six weeks. This is the method for families who cannot tolerate sustained crying.

The right method depends on two things: your baby's temperament and your own tolerance. A baby who escalates quickly when left alone may do better with the chair method. A baby who becomes more stimulated by a parent's presence may do better with extinction. A parent who cannot listen to prolonged crying without intervening should not attempt extinction, because breaking mid method and going in teaches the baby that escalation works.

Whatever you choose, choose before night one. Discuss it with your partner. Agree on the specifics. Write it down. The worst time to make a decision about sleep training is in the middle of it.

#### THE LESSON

No single method is right for every family. But no method works without consistency. Pick one, understand it, agree on it, and hold the line.

## TRY THIS

---

1. Read all five methods above and identify the one that matches both your baby and your tolerance. Be honest about your tolerance. Picking a method you cannot sustain is worse than picking a gentler one you can.
2. Discuss the plan with your partner before night one. Agree on the specific intervals, the maximum crying time you are both comfortable with, and what you will do if one of you wants to quit. Make these decisions while rested.
3. Check the prerequisites. Baby is four months or older, adjusted for prematurity. Pediatrician has cleared them. No active illness, ear infection, or untreated reflux. No vaccination in the past 24 to 48 hours, post vaccine fussiness and low fever make it impossible to distinguish training crying from a medical reaction, and it is not fair to start on a baby who may be genuinely uncomfortable. No major life disruptions in the next two weeks. If your baby snores loudly, appears to struggle to breathe during sleep, or has pauses in breathing, speak with your pediatrician before starting, these can be signs of obstructive sleep apnea, which requires medical evaluation, not behavioral training.
4. Write the plan on paper and put it somewhere visible. When it is 2 AM and the baby is crying and you cannot think straight, the plan thinks for you.
5. If you are not sure, start with graduated extinction. It has strong evidence, a built in role for the parent during check ins, and it is the method that works for the widest range of babies and families.

## THE GUILT

---

You are going to feel guilty. That is not a prediction. It is a certainty.

You will feel it when the crying starts. You will feel it when you walk away from the door. You will feel it when night two is harder than night one and you are standing in the hallway wondering what kind of parent does this. You may feel it even if everything goes smoothly. The guilt does not require things to go wrong. It is a feature of the situation, not a signal that something is.

Here is what the research says about that guilt.

Gradisar's 2016 randomized trial measured cortisol in trained and untrained infants. Cortisol declined over time in the trained group. Attachment scores at twelve months showed no differences. The babies were not more stressed. They were sleeping better.

Price and colleagues followed 326 families for five years. Zero differences in emotional health. Zero differences in behavior. Zero differences in parent child closeness. They looked specifically for harm. They did not find any.

The guilt you will feel is not information about what is happening to your baby. It is information about you, that you are a parent who cares deeply about causing your child distress. That instinct is correct and good. It is just misfiring on this particular situation, where the short term distress has been studied extensively and the long term outcomes are clear.

You are not a bad parent for doing this. The research has answered that question. You are a parent who did the reading.

## Chapter 6: Game Night

### FIRST SON & SECOND SON

---

I do not remember what night one with First Son looked like because there was no night one. There was no plan. Sleep training happened in fragments over months, a few attempts at letting him cry that we abandoned after ten minutes, a few weeks of trying a looser routine, a gradual and accidental drift toward something that eventually worked long after it needed to.

Night one with Second Son, I remember in detail.

We did the bedtime routine. Bath at 6:40. Pajamas and sleep sack. Bottle at 6:55, lights dimmed, in my arms but I kept him awake. Two short books. I said, "I love you, it's time to sleep." I put him in the crib on his back. He looked at me. I walked out and closed the door.

He started crying within thirty seconds.

I set the timer for three minutes. Those three minutes were the longest of my life. When the timer went off, I went in. I did not pick him up. I put a hand on his chest, said "You're okay, I love you," and walked out. I set the timer for five minutes.

He cried harder.

My wife was in the living room. She asked me how long we were going to do this. I said we agreed on the plan. She said she knew, but this was different than she expected. I said I know.

I went back in at five minutes. Same thing. Hand on chest. Brief words. Out.

Set the timer for ten minutes. Repeated at ten minute intervals.

He fell asleep forty seven minutes after I put him down.

Night two, he cried for about thirty minutes. I went through the same intervals. My wife stayed in the bedroom with the door closed. She told me later she listened to a podcast with the volume all the way up.

Night three, fifteen minutes of crying. By the time I went in for my first check at three minutes, he was already winding down.

Night four, ten minutes.

Night five, he fussed for about five minutes. Not hard crying. Just adjusting.

Night six, three minutes of quiet fussing.

Night seven, I put him down, walked out, and that was it. He rolled to his side and closed his eyes.

I stood in the hallway and did not know what to do with myself. For the first time in months, the evening was mine.

## THE SCIENCE

---

This chapter walks through the graduated extinction protocol in detail, the second method described in Chapter 5. If you chose a different approach, the nightly expectations and emotional preparation below still apply, but the specific intervals and check in structure will differ.

The night by night progression described above is consistent with what the research predicts for graduated extinction. A 2006 study by Mindell and colleagues found that over 80 percent of children showed clinically significant improvement within the first week. A common pattern is peak crying on night one or two, followed by rapid decline.

Some babies experience what researchers call an extinction burst on night two: the behavior temporarily intensifies before it extinguishes. If night two is worse than night one, this is not a sign of failure. It is a sign the process is working. The old behavior is getting its last test before the baby moves on.

The protocol I followed is standard graduated extinction:

Before bed. Follow your established routine. The same sequence, same length, same ending. Feed happens at the beginning, not the end. Baby goes into the crib drowsy but awake.

At bedtime. Place baby in the crib. Say your phrase. Leave the room.

Check ins. Return at three minutes, five minutes, then every ten minutes. Checks are brief, thirty seconds or less. You may place a hand on the baby, speak quietly, but do not pick them up and do not stay. The check is for your reassurance as much as theirs.

Night wakings. Apply the same protocol. If a feeding is still appropriate for your baby's age, feed in dim light with minimal interaction, then return baby to the crib awake and resume intervals.

Night feeds. Most five- to six month olds still need one feed per night. Most seven- to eight month olds do not, though you should confirm with your pediatrician. If you are maintaining a feed, keep it businesslike. Dim room, no talking, no eye contact. Feed, burp, crib, out. The reason is stimulation: talking, eye contact, or any interaction makes it more likely the baby wakes more fully and requires a longer settling time. The goal is to meet the caloric need without triggering a complete waking. Businesslike is not cold, it is kind.

There are two things that can derail this process.

The first is inconsistency. If you go in and pick the baby up after thirty minutes on night one, you have taught the baby that thirty minutes of crying produces results. The next night, they will cry for at least thirty minutes. If you then hold out for forty five, you have raised the threshold. You are training the baby to cry longer, not shorter.

If you do go in and pick them up, because you are human and sometimes you will, here is what to do next. Put them back down when they are calm but still awake. Resume your intervals from the beginning. One pick up does not erase the method. It sets it back by roughly one night, not seven. Get back on the plan as quickly as you can and hold to it for the rest of the session. The training is not ruined. It is delayed.

Consistency is not optional. It is the method.

The second is starting before both parents are fully committed. If one parent wants to do this and the other is going along reluctantly, night two will break you. The reluctant parent will want to stop. The committed parent will want to push through. The argument that follows will be louder than the baby. Have the conversation before night one. Agree on the plan. Agree on the intervals. Agree on what you will do if one of you wants to quit. If you cannot reach agreement, you are not ready.

#### THE LESSON

Sleep training is simple but not easy. The method is straightforward. The execution requires more resolve than most parenting tasks you will face. Prepare for the hardest part to be over in 48 hours.

#### TRY THIS

---

1. Start on a Friday or Saturday night. You will be tired the next day. Do not have obligations that require sharp thinking.
2. Set timers. Do not estimate. When you are standing in a dark hallway listening to your baby cry, three minutes feels like thirty. Use your phone. Trust the numbers, not your feelings.
3. Give your partner a job. If one of you is doing the check ins, the other should be somewhere they cannot hear, or doing something that occupies their attention. Two parents standing in the hallway feeding each other's anxiety makes everything harder.

4. Do not check the monitor obsessively. Check it if the crying changes in character, a sudden scream versus a wind down cry. A wind down cry sounds different from distress once you have heard it: it reduces in intensity rather than escalating, it is interrupted by lengthening pauses, and the silence between bursts grows longer. If the crying is still climbing in volume and urgency after twenty minutes, go in for a check. If it is cycling down with breaks, trust the timer and stay away from the screen.
5. Commit to seven nights before evaluating. Most families see dramatic improvement by night three or four. But seven nights of consistency is what separates a trained baby from a baby who had one good night.
6. Have a plan for your body during the intervals, not just your schedule. Standing in a quiet hallway listening to your baby cry is one of the hardest things you will do as a parent. Your nervous system will fire every alarm it has. Do not stand there. The parent not doing check ins should be somewhere they cannot hear, a shower, a walk around the block, a loud podcast, folding laundry. The parent doing check ins should have the timer in hand and eyes off the monitor. When the alarm is going off in your chest, movement and action help more than stillness. You are not abandoning your baby. You are waiting out a window that is measured in minutes.

## Chapter 7: The Team

### FIRST SON & SECOND SON

---

The worst argument my wife and I had in the first year of First Son's life was not about money or time or whose turn it was to change a diaper. It was about sleep.

She wanted to go in. I wanted to wait. Or she wanted to wait and I wanted to go in. It changed night to night because we had no plan, so every decision was made in real time by two people who were exhausted and scared.

The arguments were never really about the baby. They were about fear. Is he okay. Are we hurting him. What if we are doing this wrong. Neither of us had answers because neither of us had done the research. We were making it up and blaming each other when it did not work.

With Second Son, we had the argument before night one. We sat at the kitchen table during nap time and talked through the plan. She told me she was not sure she could listen to him cry for more than twenty minutes. I said the research suggested it could go longer on the first night. We agreed on a cap: if he was still crying hard after an hour, we would go in together, soothe him, and try again the next night.

We never hit the cap. But having it there gave my wife permission to trust the process. She was not handing control to me. She was agreeing to a plan that had a boundary she could live with.

That conversation took twenty minutes. It saved us weeks of conflict.

### THE SCIENCE

---

Research on infant sleep consistently identifies caregiver consistency as one of the strongest predictors of successful outcomes. A 2020 study published in *Frontiers in Psychiatry* reviewed 23 studies on parental cognitions and infant sleep and found that parental difficulties with limit setting were among the most frequently implicated factors in persistent sleep problems. When parents disagreed about the approach or one parent undermined the other's efforts, training took significantly longer.

The research on father involvement specifically is newer but consistent. A 2010 study by Tikotzky and colleagues, published in the *Journal of Pediatric Psychology*, followed 56 couples through the first six months. Higher father involvement in infant caregiving predicted fewer night wakings, even after controlling for breastfeeding. A 2020 study by Ragni and De Stasio found that paternal involvement at bedtime was the single strongest predictor of reduced bedtime difficulties, more powerful than any maternal variable measured.

A systematic review published in 2021, covering 26 studies on fathers and infant sleep, concluded that when fathers are more involved in their children's sleep care, infants and toddlers display more consolidated sleep patterns.

This does not mean sleep is a father's job. It means sleep is a team operation, and teams perform better when both members are active.

There is a practical reason to have the non nursing parent take the lead during training nights. If the baby is breastfed, the nursing parent smells like food. The baby's arousal in the presence of the nursing parent is higher, and the association between that parent and feeding is strong. The non nursing parent does not carry those associations, which can make check ins less stimulating for the baby.

This is biology, not a statement about who cares more.

It is also worth naming something the research supports: mothers and fathers typically do not experience sleep training nights the same way. Mothers, particularly those who are breastfeeding, show higher physiological arousal in response to infant crying and report stronger urges to intervene. This is not a character difference. It is hormonal architecture. The postpartum and nursing state creates a different relationship between a mother's nervous system and her baby's distress signal. She is biologically primed to respond.

This does not make her less capable of following the plan. It means the plan will cost her more than it costs her partner on the hard nights, and pretending otherwise does not help either of them. The non nursing parent taking the lead on check ins is not just practical. For many families, it is the only way the nursing parent survives night one without breaking.

#### THE LESSON

Sleep training is a team decision that tests the team. The plan you make together before night one matters as much as anything you do during the night.

#### TRY THIS

---

1. Have the conversation before night one. Not in bed. Not at midnight. During the day, when you are both rested. Agree on the method, the intervals, and the cap you are both comfortable with.
2. Assign roles. One parent does check ins on training nights. The other parent stays away from the door. Switch roles if needed, but do not both stand in the hallway.
3. Write the plan down and put it on the fridge. At 2 AM, you will not remember what you agreed to. The paper remembers.
4. If you are the non nursing parent, take the lead on bedtime routine and training nights. This is one of the most valuable things you can do in the first year.
5. After a hard night, debrief in the morning. What worked. What was hard. What you want to adjust. Do this over coffee, not in the dark at 3 AM.
6. If your partner cannot or will not participate, you can still do this. The research requires consistency, not two people. A single committed caregiver following the plan produces the same outcomes as a coordinated pair. It is harder, the emotional weight falls on one person, and there is no one to hand the check ins to. But it works. If your partner is absent, unwilling, or actively unsupportive, do not let that become the reason you do not start. Inform them of the plan, ask them not to undermine it, and proceed. You do not need their help. You need their non interference.
7. Prepare a short script for people who push back. Grandparents, friends, in laws who visit during training week, you will encounter someone who is skeptical, upset, or vocal. You do not need to defend the research at the dinner table. You need one calm sentence: "We looked at the research and made a decision that felt right for our family. We need one week of consistency. We would love your support." Then close the conversation. You are not asking for permission. You are asking for non interference. There is a difference.

# Chapter 8: The Feeding Factor

## FIRST SON & SECOND SON

---

My wife breastfed both boys. With First Son, the last thing she did every night was nurse him to sleep. It worked beautifully for the first three months. He would latch, drift off, and she would lower him into the crib like she was defusing a bomb. Sometimes it held. Often it did not, and twenty minutes later he was up again.

By month four, nursing to sleep was the only way he would go down. Not rocking, not bouncing, not me. Only nursing. My wife was the sole bedtime parent. She was also the sole 1 AM parent and the sole 4 AM parent. I felt useless. She felt trapped. We were both right.

With Second Son, we moved the last feed to the start of the bedtime routine at six weeks. She nursed him in the living room with the lights on. Then I took over. Bath, pajamas, books, crib. He learned to associate the crib with sleep, not the breast with sleep. My wife still fed him, but the feed was separated from the act of falling asleep by twenty minutes of routine.

When we started sleep training at five months, the transition was smoother because the strongest sleep association, nursing, had already been decoupled from bedtime.

## THE SCIENCE

---

Breastfed babies wake more often at night than formula fed babies. A systematic review of 21 studies covering over 6,000 infants found that exclusively breastfed infants under six months had a greater number of night wakings. However, most studies found no difference in total sleep duration. Breastfed babies woke more but their overall sleep was not shorter.

There is an important reason for this. Breast milk digests faster than formula, so hunger returns sooner. But breast milk also contains melatonin in concentrations that rise at night, and the hormones prolactin and oxytocin released during nursing have sedating effects that help the nursing parent return to sleep more quickly. Research suggests breastfeeding mothers typically fall back asleep faster after night feeds than formula feeding mothers. The net effect is that breastfeeding parents often get more total sleep despite more wakings.

After six months, the differences between breast and formula fed infant sleep largely disappear. A study of infants aged six to twelve months found no difference in night waking frequency between the two groups. By this age, most night wakings are driven by sleep associations, not hunger.

The practical issue is not the milk. It is the association. When nursing is the last thing that happens before sleep, it becomes a sleep onset association. The baby links the physical act of sucking, the warmth of the parent, and the taste of milk with the transition from awake to asleep. When they wake between sleep cycles and those conditions are absent, they cannot get back to sleep without them.

Moving the feed to the beginning of the routine breaks this link. The baby still gets the feed. They just do not fall asleep during it.

Night weaning follows a separate timeline. Most five- to six month olds still need one nighttime feed. Most seven- to eight month olds who are eating solids during the day do not need nighttime calories, though some still benefit from one feed. By nine months, the vast majority of healthy, typically developing babies can go twelve hours without eating. Confirm with your pediatrician based on your baby's weight and growth.

To wean a night feed, reduce the volume or duration by one ounce or two minutes every two to three nights. Alternatively, go cold turkey if your baby is eating well during the day and your doctor agrees.

#### THE LESSON

Breast milk and formula both support good sleep. The feeding method matters less than whether the feed happens at the start of the bedtime routine or the end.

#### TRY THIS

---

1. Move the last feed to the beginning of the bedtime routine. Feed in a lit room, not the nursery. Keep the baby awake during the feed. Then hand off to the other parent for the rest of the routine.
2. If you are breastfeeding, introduce a bottle for the bedtime feed once nursing is established, typically around four to six weeks. This lets the non nursing parent take over bedtime and breaks the nursing to sleep association.
3. Do not assume formula will solve a sleep problem. The research does not support the common belief that formula fed babies sleep better. The difference is marginal and disappears by six months.

4. Night wean gradually unless your pediatrician says otherwise. Reduce the feed by a small amount every few nights. Cold turkey is fine for older babies who are eating well during the day.
  
5. If your baby wakes at night and you are unsure if they are hungry, ask: are they eating well during the day? Have they gained weight appropriately? When was the last feed? If the answers suggest they are not hungry, it is a sleep association, not a calorie need.

# Chapter 9: Naps

## FIRST SON & SECOND SON

---

Nighttime sleep training with Second Son took one week. Nap training took three.

I was not prepared for that. I assumed that once he learned to fall asleep independently at night, naps would follow automatically. They did not. He would go down beautifully at 7 PM and then fight his 9 AM nap like it had personally wronged him.

With First Son, naps were never trained at all. They happened in the car, in the stroller, in someone's arms, or not at all. His nap schedule was whatever worked in the moment, which meant it was never the same twice.

The thing I did not understand is that naps and nighttime are governed by different biological systems. Nighttime sleep has melatonin, darkness, and twelve hours of accumulated sleep pressure working in its favor. Naps have none of that. The biological drive to stay awake during the day is strong, and a baby's sleep pressure in the morning, when the first nap is due, is relatively low.

Naps are harder. They take longer to train. And they require their own strategy.

## THE SCIENCE

---

The research on nap training is thinner than on nighttime sleep, but the clinical consensus is clear on several points.

First, train nighttime before naps. A baby who has learned to fall asleep independently at bedtime has the foundational skill. Nap training builds on that skill in a harder context. Attempting both simultaneously overwhelms the baby and the parents.

Second, use the same method for naps as you used at night. Consistency across sleep contexts accelerates learning. If you used graduated extinction at bedtime, use it for naps.

Third, cap the attempt. If the baby has not fallen asleep after 60 minutes of trying, get them up. Try again at the next wake window. An hour of crying with no sleep is not productive and will make the baby overtired for the rest of the day. A rescue nap, in the stroller, car, or your arms, is acceptable on these days to prevent an overtired spiral.

Fourth, the first nap of the day is the easiest to train. Morning sleep pressure, while lower than nighttime, is still the highest of any daytime period. Start there. Once the first nap is solid, work on the second.

Nap transitions are a separate challenge. Babies move from four or five naps to three around four to five months, to two around seven to nine months, and to one around twelve to eighteen months. Each transition temporarily disrupts the schedule. During these transitions, bedtime should move earlier to compensate for lost daytime sleep. A 6 PM bedtime during a nap transition is not a mistake. It is a strategy.

The two to one nap transition, which typically happens between twelve and eighteen months, is the hardest. It often takes two to four weeks of inconsistency before the single nap consolidates. During this time, the baby may need one nap some days and two on others. Follow their cues and keep bedtime flexible.

#### THE LESSON

Naps are the second half of sleep training and the harder half. They follow nighttime, not the other way around. Expect them to take longer and require more patience.

#### TRY THIS

---

1. Wait one to two weeks after nighttime sleep is solid before starting nap training. Let the nighttime skill consolidate first.
2. Cap nap attempts at 60 minutes. If the baby is not asleep, get them up and try at the next wake window. Use a rescue nap if needed to avoid an overtired day.
3. Start with the first nap of the day. It is the one with the most biological support. Once it is consistent, address the others.
4. During nap transitions, move bedtime earlier. A baby who dropped a nap and is now awake for a long afternoon stretch needs an earlier bedtime, not a later one.
5. Accept that naps will be less predictable than nighttime for a long time. Night sleep consolidates first. Naps follow on their own developmental timeline.

# Chapter 10: The Co Sleeping Question

## FIRST SON & SECOND SON

---

I told the story of falling asleep with First Son on the couch in the Safe Sleep chapter. Here is the rest of it.

After that scare, my wife and I made a rule: no baby on the couch or recliner under any circumstances. We followed it. But there were nights, particularly during the worst stretches around seven and eight months, when we brought First Son into our bed. Not because we had read the research and made an informed decision. Because it was 3 AM and nothing else was working and we were desperate.

We did not tell our pediatrician. We did not look up how to do it safely. We just did it, badly, with pillows and a thick comforter and the vague hope that nothing bad would happen.

Nothing bad happened. But looking back, the way we did it was among the most dangerous options available. Not because bed sharing is inherently deadly, but because uninformed, reactive bed sharing done out of exhaustion, with the wrong setup, is where the real risk lives.

With Second Son, we did not need to bed share because sleep training resolved the night wakings. But I am writing this chapter because the data says most of you will co sleep at some point whether you plan to or not, and you deserve real information instead of silence.

## THE SCIENCE

---

A 2024 study published in Family Relations found that 64 percent of parents who did not intend to co sleep were doing so by the time their baby was two months old. Eighty eight percent of those who tried it found it preferable to the alternative.

The American Academy of Pediatrics is clear in its position: "On the basis of the evidence, the AAP is unable to recommend bed sharing under any circumstances." This recommendation is based on epidemiological data showing that bed sharing is associated with an increased risk of sudden unexpected infant death, particularly in the presence of specific risk factors: parental smoking, alcohol or drug use, soft bedding, couch or recliner sleeping, and preterm or low birth weight infants.

However, not all bed sharing carries the same risk.

A study by Blair and colleagues followed SIDS cases and controls for eight years. For parents who smoked, bed sharing increased risk nearly 14-fold. For non smoking parents in the absence of other hazards, the increased risk was 2.09 and was not statistically significant. This does not mean the risk is zero. It means the study did not have enough participants in this subgroup to confirm or rule out a risk of that magnitude with confidence. There is meaningful uncertainty here, not reassurance.

Emily Oster, an economics professor at Brown University and author of *Cribsheet*, analyzed the risk data and estimated that bed sharing in the safest possible configuration, non smoking parents, no alcohol, firm mattress, breastfeeding, healthy full term baby, carries a risk of approximately 0.15 per 1,000. That is not zero. But it sits against a baseline infant mortality rate of approximately 5 per 1,000.

The countries with the lowest SIDS rates in the world, including Japan and the Netherlands, have high rates of bed sharing but also have low smoking rates and different sleep surface norms.

The Academy of Breastfeeding Medicine, in its 2019 protocol, acknowledged that accidental bed sharing, falling asleep unintentionally on a couch or in a chair, may be more dangerous than intentional, planned bed sharing on a safe surface. The UK, Spain, and Norway have moved toward harm reduction guidance rather than blanket prohibition, advising parents who choose to bed share on how to minimize risk.

None of this overrides the AAP recommendation. It provides context.

If you choose to bed share, the Safe Sleep Seven framework describes the lowest risk conditions: both parents are non smokers, both are sober, the mother is breastfeeding, the baby is healthy and full term, the baby is placed on their back, bedding is light with no pillows near the baby, and the surface is a firm mattress with no gaps.

If any one of those conditions is not met, the risk profile changes meaningfully.

A note for formula feeding parents: the Safe Sleep Seven was developed specifically for breastfeeding families. The breastfeeding condition is associated with lighter maternal sleep and more frequent arousal, which contributes to the lower risk profile. Formula feeding parents who share a bed should observe all other conditions carefully. The risk profile is not identical, but the practical steps, non smoking, sober, firm mattress, no loose bedding, baby on their back, apply regardless of feeding method.

#### THE LESSON

Most parents will co sleep at some point. The safest thing I can do is give you the facts, not pretend it does not happen. Know the AAP recommendation. Know the risk factors. Make an informed decision.

#### TRY THIS

---

1. Follow the AAP recommendation as your baseline: room sharing on a separate surface for the first six months.
2. If you find yourself bringing the baby into bed out of exhaustion, make the bed as safe as possible first. Remove extra pillows, heavy comforters, and anything soft. This takes thirty seconds and matters enormously.
3. Never fall asleep with a baby on a couch, recliner, or armchair. This is the highest risk sleep scenario and the one most often associated with infant death. If you feel yourself drifting off, put the baby in the crib first.
4. Have a plan for the 3 AM breaking point. Discuss with your partner in advance what you will do when you are both beyond exhausted and the baby will not settle. A safe fallback is better than a desperate improvisation.
5. Do not let shame prevent you from being informed. If you are going to bed share, do it with the lights on, metaphorically. Know the risk factors. Eliminate the ones you can.

# Chapter 11: Regressions

## FIRST SON & SECOND SON

---

At ten months, Second Son stopped sleeping through the night.

Three weeks earlier, everything was perfect. Down at 7, asleep in minutes, up at 6:30. Then, without warning, he started waking at midnight, crying in a way he had not cried since the first week of training. Standing up in his crib. Screaming when I left the room.

My first thought was that sleep training had failed. That we had done it wrong, or it had worn off, or he had somehow unlearned everything.

None of that was true. He was going through the eight to ten month developmental surge. He had just started pulling up to stand. Separation anxiety had kicked in. His brain was busy, and the busyness was spilling into the night.

With First Son, I would have responded by going back to old habits. Rocking, holding, feeding to sleep, whatever stopped the crying in the moment. With Second Son, I held the line. Same routine. Same response. Check ins at intervals. No new sleep associations.

It lasted eleven days. Then it was over, and he was back to sleeping through the night as if nothing had happened.

The difference was not the regression. It was what I did during it.

## THE SCIENCE

---

Sleep regressions are predictable developmental events. They are not regressions at all. They are progressions. Sleep disrupts because the brain is busy building new capacities, and the construction noise wakes the baby up.

The major regressions occur at fairly consistent ages.

Four months. Sleep architecture permanently matures from newborn style to adult style cycling. This is the most disruptive regression and the only one that represents a permanent biological change. It is not temporary in the way the others are. The new sleep architecture is here to stay. What is temporary is the adjustment period. If the baby has not yet learned to fall asleep independently, this is the regression that forces the issue.

Eight to ten months. Mobility surges: crawling, pulling to stand, cruising. Separation anxiety peaks. Cognitive leaps in object permanence mean the baby now understands that you exist when they cannot see you, and they want you back. This regression typically lasts two to four weeks.

Twelve months. Walking, language emergence, and the beginning of the two to one nap transition. Some babies temporarily refuse a nap, leading parents to think they are ready to drop to one. Most twelve month olds are not ready. Continue offering two naps and move bedtime earlier if the second nap is refused.

Eighteen months. Language explosion, willfulness, boundary testing. The toddler can now say no and mean it. Separation anxiety resurfaces. This regression can last two to six weeks and often coincides with a genuine nap transition.

The clinical guidance for all regressions is the same: maintain consistency. Do not introduce new sleep associations to cope with a temporary disruption. The habits you create during a regression will outlast the regression itself. If you start rocking to sleep again during the eight month surge, you will be rocking to sleep long after the surge is over.

Extra comfort during the day is appropriate and helpful. More connection time, more physical contact, more responsive interaction during waking hours. But at bedtime, the routine stays the same and the expectations stay the same.

If a regression undoes your progress and you have been inconsistent during it, you may need a brief retraining period. This is almost always faster than the initial training. The skill is still there. The baby just needs a reminder. Expect two to four nights to get back on track.

#### THE LESSON

Regressions are not failures. They are signs of growth. What you do during them determines whether they last two weeks or two months.

#### TRY THIS

---

1. Know the timeline. Mark the approximate dates of the four month, eight month, twelve month, and eighteen month regressions on your calendar. When sleep falls apart near one of those markers, the cause is probably developmental.
2. Do not change the rules. Same bedtime routine, same response to night wakings, same expectations. The regression is temporary. The habits you build during it are not.

3. Add connection during the day. Extra playtime, extra holding, extra eye contact. A baby going through a developmental leap needs more reassurance during waking hours. Give it generously so you do not need to give it at 2 AM.
4. If illness coincides with a regression, comfort freely and suspend training. Resume three to five days after recovery. Expect a few nights of retraining.
5. If you lose ground, go back to your original method. Start at night one intervals. It will go faster this time. The foundation is still there.

# Chapter 12: The Toddler

## FIRST SON & SECOND SON

---

First Son climbed out of his crib at twenty months.

He did it at 5:30 AM on a Tuesday. I heard a thud and then silence and then the sound of his bedroom door opening. He wandered into our room like it was nothing. I was horrified. My wife thought it was funny. I spent the rest of the day looking up crib tents before learning they had been recalled.

We transitioned him to a toddler bed that week, mostly out of fear. In hindsight, this was too early. He was not ready for the freedom of an open bed. He spent the next three months getting up repeatedly after lights out, appearing in our doorway, asking for water, asking for another book, asking to go potty, and deploying every other delay tactic available to a two year old's imagination.

With Second Son, I kept him in the crib until he was nearly three. He never climbed out. When we transitioned him, he already had the language to understand the rules and the impulse control to mostly follow them.

The difference was not the child. It was the timing.

## THE SCIENCE

---

Most sleep experts recommend keeping a child in a crib as long as safely possible, ideally until age two and a half to three. The crib is a contained, predictable sleep environment. A toddler bed introduces freedom of movement, which introduces the possibility of getting up, leaving the room, and engaging in the stalling behavior that exhausts parents of toddlers worldwide.

If your child climbs out of the crib, lower the mattress to the lowest setting. Remove anything in the crib they could use as a step. If they continue climbing out, transition to a bed for safety, regardless of age.

When you do transition, keep everything else the same. Same routine, same room, same expectations. The only change is the sleep surface. Introduce a toddler clock, a device with a light that changes color at a set time. The rule is simple: when the light is red, it is sleep time. When it turns green, you can get up. This gives the child a concrete, external boundary rather than relying entirely on parental enforcement.

Toddler stalling is universal and developmentally normal. "I need water." "One more book." "I have to go potty." "There is a monster." These are delay tactics in approximately 95 percent of cases. The effective response is calm, brief, and final. One trip to the bathroom after books. One sip of water. Then the door closes and the interaction ends.

The bedtime pass technique is a structured way to handle this. Give your toddler one pass per night. They can use it for one request: a hug, a drink, a trip to the bathroom. Once the pass is used, no more requests are honored. Research on the bedtime pass by Friman and colleagues found it significantly reduced bedtime resistance with minimal distress.

Nighttime fears typically emerge around age two to three as imagination develops. These are real to the child and should be validated, briefly. "I understand you feel scared. You are safe. I am right here." Do not spray monster spray or check under the bed. These responses, while well intentioned, confirm the premise that there might be something to be afraid of. Instead, offer a nightlight, a comfort object, and a brief reassurance. Then leave.

Night terrors are different from nighttime fears, and you should know what they look like before you encounter one. A child having a night terror appears awake, eyes open, possibly screaming or thrashing, but they are not conscious and cannot be reached. They will not respond to your voice the way they normally would. They will have no memory of it in the morning.

Night terrors are a NREM sleep phenomenon, not a behavioral one. They occur one to three hours after sleep onset, during deep sleep, and affect roughly 30 percent of toddlers. They are not caused by sleep training, by something frightening that happened during the day, or by anything you have or have not done.

The correct response is the one that feels wrong: do not try to wake the child, do not hold them still, do not call their name repeatedly. Stay nearby, make sure they cannot hurt themselves, and wait. The episode will pass in 5 to 15 minutes on its own. Attempting to console a child mid terror typically extends it. Night terrors do not signal a problem with your bedtime routine or training approach and do not require any change to your method.

#### THE LESSON

The toddler phase is not a new problem. It is the same problem in a bigger body with better negotiating skills. Consistency and clear boundaries still work. They just require more resolve.

#### TRY THIS

---

1. Keep your child in the crib until at least two and a half unless safety requires an earlier transition. The crib is your ally. Do not give it up prematurely.
2. When you transition to a bed, use a toddler clock. Set the green light for an appropriate wake time and enforce it consistently. The clock becomes the authority, not you.
3. Give your toddler one bedtime pass per night. One request, then done. This gives them a sense of control while maintaining a firm boundary.
4. For nighttime fears, validate the feeling and redirect. "Scared feelings are real. Monsters are not. Here is your bear, here is your light, I love you, good night."
5. Do not engage in negotiations after lights out. Every response to a stall tactic, no matter how reasonable it sounds, teaches the child that the conversation is still open. One response. Then silence.

## Chapter 13: After the Game

When Second Son started sleeping through the night, I did not know what to do with the evenings. That sounds ridiculous. But for months, my nights had been structured around feeding, rocking, checking the monitor, and lying in bed wondering if the next wake up was five minutes or five hours away.

Suddenly I had three hours between his bedtime and mine. My wife and I sat on the couch and looked at each other. She said, "What do we do now?" I said, "I have no idea." We watched a movie. The whole thing. Without pausing. It felt like a vacation.

Sleep training gave us that back.

It also gave us something harder to measure. I stopped dreading bedtime. My wife stopped resenting me for not being able to help with the night feeds she was carrying alone. We started talking about things other than the baby's schedule. We started being people again, not just parents in survival mode.

The research says we made the right call. Gradisar's 2016 trial found no attachment differences at twelve months. Price's 2012 study found no emotional, behavioral, or relational differences at age six. Hiscock's 2008 study found significant improvements in maternal mood and fatigue. The Mindell meta analysis found that 94 percent of 52 studies reported effective outcomes.

The evidence is not ambiguous. Sleep training works. It is safe. And the families who do it are not just sleeping better. They are functioning better.

But here is what the research cannot capture. The morning after the first full night of sleep, I picked up Second Son from his crib and he smiled at me. Not a tired, overstimulated, middle of the night smile. A rested, bright eyed, happy to see you smile. He had slept well. So had we.

That is what 133 nights of lost sleep looks like when you get them back. It looks like a Tuesday morning where everyone is rested and everything feels possible.

# Appendix A: The Sleep Plan Worksheet

Baby's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Feeding Method:  Breast  Formula  Combo

Current Sleep Associations (check all that apply):

Nursing/bottle to sleep  Rocking  Bouncing  Pacifier  Being held  Cosleeping  Motion (car/stroller)

**Medical Considerations:**

None  Reflux  Allergies  Ear infections  Premature (adjusted age: \_\_\_\_)

**Chosen Method:**

Extinction  Graduated Extinction  Chair Method  Pick Up/Put Down  Bedtime Fading

**Check in Intervals (if graduated extinction):**

Night 1: \_\_\_\_ min / \_\_\_\_ min / \_\_\_\_ min (then every \_\_\_\_ min)

Night 2: \_\_\_\_ min / \_\_\_\_ min / \_\_\_\_ min (then every \_\_\_\_ min)

**Bedtime Routine:**

1. \_\_\_\_\_ (time: \_\_\_\_)
2. \_\_\_\_\_ (time: \_\_\_\_)
3. \_\_\_\_\_ (time: \_\_\_\_)
4. \_\_\_\_\_ (time: \_\_\_\_)
5. Into crib AWAKE (time: \_\_\_\_)

**Night Feed Plan:**

Maintaining \_\_\_\_ feed(s)  Weaning  No night feeds

**Parent Agreement:**

We agree to follow this plan consistently for seven nights before evaluating.

Signed: \_\_\_\_\_ & \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix B: Quick Reference

### Wake Windows by Age

Age	Awake Between Sleeps	Naps	Bedtime
0 to 4 weeks	30 to 60 min	5 to 7	Variable
4 to 12 weeks	60 to 90 min	4 to 5	8 to 10 PM
3 to 4 months	75 min-2 hours	3 to 4	7 to 8:30 PM
5 to 7 months	2 to 3 hours	3	6:30 to 8 PM
7 to 10 months	2.5 to 3.5 hours	2	6:30 to 7:30 PM
10 to 14 months	3 to 4 hours	1 to 2	7 to 8 PM
14 to 24 months	4 to 6 hours	1	7 to 8 PM

### Regression Quick Reference

Age	What Is Happening	What to Do
4 months	Sleep architecture matures permanently	Begin sleep training if ready
8 to 10 months	Mobility, separation anxiety, object permanence	Hold the line, add daytime connection
12 months	Walking, language, nap transition begins	Keep offering two naps, earlier bedtime
18 months	Willfulness, language explosion, boundary testing	Firm limits, same routine, patience

### Safe Sleep ABCs

- Alone, Nothing in the crib but baby and a fitted sheet
- Back, Every sleep, every time
- Crib, Firm, flat, meets CPSC standards

### When to Call Your Pediatrician

- Baby is crying for two or more hours with no improvement over multiple nights
- Snoring, gasping, or pauses in breathing during sleep

- You suspect reflux, ear infection, or another medical issue affecting sleep
- Baby was premature and you are unsure about adjusted age for training
- You are experiencing symptoms of postpartum depression or anxiety

## Appendix C: Sources and Further Reading

Mindell, J.A., Kuhn, B., Lewin, D.S., Meltzer, L.J., & Sadeh, A. (2006). Behavioral treatment of bedtime problems and night wakings in infants and young children. *Sleep*, 29(10), 1263 to 1276. The landmark meta analysis. 52 studies. 94% found interventions effective.

Gradisar, M., Jackson, K., Spurrier, N.J., et al. (2016). Behavioral interventions for infant sleep problems: A randomized controlled trial. *Pediatrics*, 137(6). Cortisol declined in treatment groups. No attachment differences at 12 months.

Price, A.M.H., Wake, M., Ukoumunne, O.C., & Hiscock, H. (2012). Five year follow up of harms and benefits of behavioral infant sleep intervention. *Pediatrics*, 130(4), 643 to 651. No differences at age 6 in any measure.

Hiscock, H., Bayer, J.K., Hampton, A., Ukoumunne, O.C., & Wake, M. (2008). Long term mother and child mental health effects of a population based infant sleep intervention. *Pediatrics*, 122(3), 621 to 627.

Tikotzky, L., Sadeh, A., & Glickman Gavrieli, T. (2010). Infant sleep and paternal involvement in infant caregiving during the first 6 months of life. *Journal of Pediatric Psychology*, 36(1), 36 to 46.

Mindell, J.A., Telofski, L.S., Wiegand, B., & Kurtz, E.S. (2009). A nightly bedtime routine: Impact on sleep in young children and maternal mood. *Sleep*, 32(5), 599 to 606.

### Recommended Books

*Precious Little Sleep* by Alexis Dubief. The most accessible and entertaining evidence based sleep book. Covers newborn through preschool.

*Cribsheet* by Emily Oster. A data driven look at every early parenting decision, including sleep training and cosleeping.

*Solve Your Child's Sleep Problems* by Richard Ferber. The original graduated extinction guide. Dense but comprehensive.

*It's Never Too Late to Sleep Train* by Craig Canapari. Written by the director of the Yale Pediatric Sleep Center. Excellent for older babies and toddlers.

## Appendix D: Is This Normal?

First time parents spend a significant portion of the first year asking some version of this question. The answer, in most cases, is yes. Here are the most common ones.

### **My six week old wakes every two hours all night.**

Normal. Their circadian rhythm has not developed yet. Sleep is scattered across the full 24 hours. You cannot fix this yet, you wait it out while building habits.

### **My four month old was sleeping three hour stretches and suddenly started waking every 45 minutes.**

Normal. This is the four month sleep maturation, a permanent change in sleep architecture, not a regression. It does not go back to the way it was. It is the signal that formal sleep training is now possible. Go to Chapter 5.

### **My baby falls asleep easily at bedtime but wakes at 1 AM, 3 AM, and 5 AM like clockwork.**

Normal sleep associations. Your baby falls asleep in one set of conditions and wakes in different ones. Chapter 2 explains this. The fix is in Chapters 5 and 6.

### **My baby cried for five minutes during training and then fell asleep without a single check in.**

Normal. Some babies do this, especially from night two onward. The absence of extended crying does not mean the training did not work. It means it worked quickly.

### **My baby does not cry during training at all, she just stands in the crib and stares at the door.**

Normal. Every baby protests differently. Standing and staring is protest. It resolves as the skill consolidates.

### **My nine month old slept through the night for three weeks and then started waking again.**

Likely the eight to ten month developmental regression. Check Chapter 11. If there is no developmental surge and no illness, two to four nights of consistent response is usually sufficient to get back on track.

### **We are on night six and it is getting worse, not better.**

Check for illness first, ear infections and teething can disrupt training mid process. If the baby is healthy, check whether you have been fully consistent. A single inconsistency can reset progress significantly. If you have been consistent and the baby is healthy, speak to your pediatrician.

### **My toddler is screaming but does not seem to recognise me when I go in.**

This may be a night terror, not a regression or nightmare. Go to Chapter 12 for what to do.

# About the Author

Jack Hartley is a father of two boys who taught him everything he knows, mostly by going in opposite directions.

His first son was the experiment. His second son was the redemption arc.

In the years between, Jack immersed himself in the research: clinical studies, academic journals, pediatric guidelines, books, podcasts, and more late night conversations with other parents than he can count. He cross referenced the conflicting advice, cut through the noise, and figured out what actually holds up.

None of it would have been possible without his wife, who has been doing this work longer, better, and with far less recognition than she deserves.

Jack is not a pediatrician. He is not a consultant, a nutritionist, or a child psychologist. He's a parent who did the reading so you don't have to and came out the other side with a clearer head, a more confident instinct, and two boys who proved that the second time around, it really does get easier.