



Turkish adaptation of the maternal cognition about infant sleep questionnaire

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ABSTRACT

Background: Exploring early childhood sleep problems requires a detailed understanding of parental beliefs and cognitions related to infant sleep. There is a need for validated measures to investigate the cognitions of Turkish mothers about infant sleep however no scale measuring parental perceptions related to infant sleep behaviors in Turkish is available. We aimed to culturally adapt the Maternal Cognitions about Infant Sleep Questionnaire (MCISQ) in Turkish.

Methods: Subjects were recruited from an internet sample through social media. Internal consistency was evaluated by Cronbach's alpha, and test-retest reliability was determined by Pearson's correlation test and paired *t*-test. For factorial validity, the principal component factor analysis was performed for the components of MCISQ.

Results: A total of 417 mothers, most aged between 25 and 29 years (47.8 %), participated in the study. Infants' age ranged between 6 and 18 months, with a mean of 10.5 ± 3.9 months. Factor analysis revealed four factors after removal of item 11: Anger, doubt, safety, limit setting. Cronbach's alpha was 0.85. A subgroup of 32 mothers completed MCISQ three weeks after the initial administration. Total mean scores showed a significantly strong correlation ($p < 0.01$, $r = 0.82$). Higher scores were noted in both total and subscale scores in infants with maternally reported sleep problems ($p < 0.01$).

Conclusion: Findings suggest a four-factor solution for MCISQ in Turkish mothers with infants aged 6–18 months. The adapted Turkish version is composed of 19 items with good reliability. Factor structure and items included in the subscales differed from the original study, highlighting the cultural factors related to maternal perceptions about infant sleep.

1. Introduction

Sleep problems are one of the common behavioral problems in early childhood and may include difficulty maintaining sleep with frequent night awakenings, sleep-onset difficulties, or inability to fall asleep without caregiver attention [1,2]. According to the most recent International Classification of Sleep Disorders 3rd edition criteria, early childhood sleep problems are included within the diagnosis of chronic insomnia disorders, and the unique aspects of presentation in children rely on the parental description of the sleep pattern of the child, such as nighttime awakenings or problematic sleep associations [3]. Therefore, the parental report is essential when evaluating pediatric sleep problems [4].

Early childhood sleep problems are of concern due to multiple impacts on the child, parents, and family and are frequently explored

within the family context. According to the transactional model of infant sleep suggested by Sadeh&Anders, multiple variables in the child, parent, and parent-child relationship influence child sleep problems [5]. These include child and parental temperament, parental stress and fatigue, and cultural and traditional beliefs related to child sleep. The parent-child relationship and parental characteristics determine parental behavior during the night, further impacting child sleep disturbances.

Cognitions related to infant sleep may influence parental behavior during the night [6]. Infant sleep problems may necessitate parental involvement at sleep onset and parental interaction during nighttime awakenings. Parents may choose more active interactions when they interpret the infant's demands at night as a sign of discomfort. Most research has focused on maternal cognitions, though recently, paternal beliefs and differences between maternal and paternal sleep-related

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cognitions are also being investigated [7].

Exploring early childhood sleep problems requires a detailed understanding of parental beliefs and cognitions related to infant sleep. Several scales have been developed to measure parental cognition about infant sleep. These scales need to be culturally adapted due to changing perceptions of infant sleep in the cultural context. Significant cross-cultural differences of sleep patterns and problems in young children and parental nighttime practices have already been identified [8]. In a study from Taiwan, the prevalence of parental reported sleep problems was 64 %, and frequent night wakings was 34 %. However, in a United States study, parental reported sleep problem was 10.5 % despite a higher frequency of infant night wakings [9,10]. Another large-scale nationwide study identified that young children living in Asian countries are more likely to bed share and room share compared to Caucasian countries [8]. These differences were interpreted as a reflection of culturally-based values such as prioritization of family interdependence or independence.

One of the most commonly used scales is the Maternal Cognitions About Infant Sleep Questionnaire (MCISQ) [11]. There is a need for validated measures to investigate the cognitions of Turkish mothers about their infants' sleep however no scale measuring parental beliefs and perceptions related to infant sleep behaviors in Turkish is available. In this study, we aimed to culturally adapt the MCISQ in the Turkish language.

2. Methods

2.1. Subjects and procedure

Subjects of this study were recruited from an internet sample through social media. The questionnaire link was shared in social media platforms to invite the participants. Data were collected anonymously. Considering the item number of the scale, a minimum of 200 participants were aimed to be reached, 10 participants per item [12]. Participants were asked to answer a question about their proximity to their children to ensure that they were mothers. The study was approved by the institutional ethics committee (protocol number:09.2023.825). On-line informed consent was obtained from the participants.

2.2. Tools

2.2.1. Maternal cognitions about infant sleep questionnaire

Maternal Cognitions about Infant Sleep Questionnaire (MCISQ) is a scale developed by Morrell JMB in 1999 to measure maternal cognitions that might be associated with infant sleep problems [11]. The original questionnaire is composed of 20 items, each rated on a 6-point (0–5) Likert scale ranging from “strongly agree [5]” to “strongly disagree (0)”. Factor analysis revealed 5 subscales: Limit setting (items 4,6,13, 18, 19); anger (items 7,10,11,12,17); doubt (items 8,9,14,15,16), feeding (items 2,5,20), safety (items 1,3). Higher scores indicate difficulty in the limit setting during night awakenings with having a low threshold for responding to infant demands for the ‘limit setting subscale’, experiencing feelings of helplessness and anger due to infant demands for the ‘anger subscale’, experiencing doubt about adequate parenting for the ‘doubt subscale’, worries about the child is feeling hungry during the night for the ‘feeding subscale’ and excessive concerns related to safety for the ‘safety subscale’. The original MCISQ was first independently translated from English to Turkish by two bilingual researchers and then translated back to English. The translations were compared and discussed until a final consensus was reached and the final version of the Turkish MCISQ was obtained.

2.2.2. Maternal report of sleep problem

The presence of sleep problem was asked mothers with one question from the revised version of the Brief Infant Sleep Questionnaire; whether they consider their infants' sleep as a problem. Mothers could answer as

follows: Not a problem, a very small problem, a small problem, a moderate problem, and a serious problem [13]. Infants whose mothers reported their infants having small, moderate, or very severe sleep problem were grouped as infants with maternally reported sleep problem.

2.3. Analysis

Statistical analyses were performed using SPSS Version 28.0 (IBM Inc., United States). For the reliability analyses, internal consistency was evaluated by Cronbach's alpha, and test-retest reliability was determined by Pearson's correlation test and paired *t*-test [14]. For factorial validity, the principal component factor analysis was performed for the components of MCISQ [15,16]. Subscales were constructed from factor loadings, and a difference of >0.10 to loadings on other factors was considered.

3. Results

A total of 417 mothers, most aged between 25 and 29 years (47.8 %), participated in the study. Characteristics of the participating women and their infants are presented in Table 1. Infants' age ranged between 6 and 18 months, with a mean of 10.5 ± 3.9 months. 25.1 % of mothers reported a moderate to severe sleep problem in their infants.

3.1. Factorial validity

3.1.1. Factor analysis

Since item 11 (When my child wakes crying, I always know what he needs) showed no correlation ≥0.3 with any other items in the scale, it was removed from the scale. In the original scale item 11 was included within the ‘Anger’ Subscale. After removing item 11, the overall Kaiser-Meyer-Olkin (KMO) measure of the scale was 0.88. The individual KMO measure was >0.7 for all items, indicating good sampling adequacy (Table 2). Bartlett's test of sphericity was statistically significant (*p*:<0.01), which indicates the principal component analysis (PCA) was appropriate to apply. Cronbach's alpha after removing item 11 was 0.85.

Although the original scale had 5 subscales, the PCA revealed four components with eigenvalue >1, which explained %30, %18.7, %6, and %5.5 of the total variance, respectively. Four components explained % 60.2 of the total variance. A varimax orthogonal rotation was employed to aid interpretability. Component loadings of the rotated solutions are presented in Table 3.

Table 1
Characteristics of the participants.

Participants	% or mean ± SD
Mothers, age, years	
<25 years	9.2
25-29	47.8
30-34	30.3
>35 years	12.7
Mother, education	
primary school	6.7
secondary school	20.6
high school	21.6
college	11.8
university	22.3
postgraduate	17.0
Infants, age, months	10.5 ± 3.9
Male	53.8
Sleep problem	
No problem	8.7
Very small problem	11.9
A Small problem	54.4
A moderate problem	14.8
A severe problem	10.3

SD: Standard deviation.

Table 2
Individual KMO measures.

Variable	KMO measure
1	0.88
2	0.90
3	0.85
4	0.88
5	0.89
6	0.79
7	0.88
8	0.94
9	0.91
10	0.89
12	0.82
13	0.81
14	0.90
15	0.89
16	0.84
17	0.82
18	0.80
19	0.83
20	0.92

Table 3
Factor analysis showing varimax rotated factor matrix.

Item	Factor 1	Factor 2	Factor 3	Factor 4
	Anger	Safety	Doubt	Limit Setting
Item 12	0.758			
Item 17	0.737			
Item 10	0.731			
Item 7	0.717	0.353		
Item 14	0.609	0.331	0.360	
Item 8	0.582	0.389		
Item 3		0.770		
Item 1	0.315	0.711		
Item 2	0.347	0.658		
Item 9		0.590	0.475	
Item 16			0.767	
Item 20		0.310	0.611	
Item 15	0.489		0.581	
Item 19			0.538	
Item 5		0.455	0.517	0.341
Item 18				0.728
Item 13			0.341	0.717
Item 4				0.701
Item 6				0.578

Factor loadings with values > 0.3 are shown.

Items loading on the factors differed from the original scale. Factor 1 contained items of 7,8,10,12,14,17. This factor was labeled as ‘anger’ in the original scale but did not contain items 12 and 14. Factor 2 was composed of items 1,2,3 and 9 and called ‘Safety’ in the original scale. Unlike the original scale, items 2 and 9 from other factors were added into Factor 2. Factor 3 contained items 5,15,16,19,20 and related to the doubt subscale in the original scale; items 5,19, and 20 from other factors appeared in this factor. The last factor contained items 4,6,13,18 and was called ‘limit setting’ in the original scale. Item 6 from the anger subscale in the original scale appeared within this factor. The ‘feeding’ subscale items in the original scale loaded on other factors in the Turkish version. As a result, none of the factors were called ‘feeding’. Cronbach’s alpha values for the new subscales were as follows: limit setting, 0.69; anger, 0.83; doubt, 0.75; safety,0.73. Final version of the questionnaire is shown in [Table 4](#).

3.2. Reliability

A subgroup of 32 mothers completed MCISQ three weeks after the initial administration. Total mean scores at times 1 and 2 were 60.3 ± 12.9 and 61.2 ± 14.5 (p:0.51) and showed a significantly strong

Table 4
Items and Factors in the Turkish version of the Maternal Cognitions about Infant Sleep Questionnaire.

Anger	7. When my child cries at night, I think I might lose control and harm him/her
	8. When my child wakes at night, I think I might not have given him/her enough attention during the day
	10. If I try to resist my child’s demands at night, then I think I might get very angry
	12. When my child cries at night and needs me, I wish he/she wasn’t so demanding
	14. When my child doesn’t sleep at night, I doubt my competence as a parent
	17. When my child cries at night, I can find myself thinking I wish I had never had a child
Safety	1. When my child cries at night, I think something awful might have happened to him/her
	2. When my child wakes at night, I think I might not have fed him/her enough during the day
	3. My child might die unexpectedly in his/her sleep
	9. I should be getting up during the night to check that my child is still all right
Doubt	5. My child might go hungry if I don’t give him/her a feed at night
	15. If I say no to my child’s demands at night, then that means I’m a bad mother
	16. I am able to let my child sleep on his/her own
	19. I am able to resist my child’s demands when he/she wakes at night
	20. If I give up feeding at night, then he/she will never sleep
Setting Limits	4. My child will feel abandoned if I don’t respond immediately to his/her cries at night
	6. It is all right to allow my child to cry at night
	13. If I try to resist my child’s demands at night, then he/she will get even more upset
	18. I should respond straightaway when my child wakes crying at night

correlation (p:<0.01, r:0.82).

3.3. MCISQ total and subscale scores

The mean total MCISQ score was 46.0 ± 12.6 and the subscale scores were as follows: Anger 10.5 ± 5.8, Safety 8.1 ± 3.5, Doubt 14.1 ± 4.9, Limit setting 13.2 ± 3.3. The variability of the total and subscale scores according to the maternal report of sleep problem is presented in [Fig. 1](#). Of note highest scores were observed in infants with small sleep problem except for anger subscale which was highest in the severe sleep problem group. Infants with small, moderate and severe sleep problems according to the maternal report were grouped as children having sleep problems to compare the scores with infants without sleep problems ([Table 5](#)). Higher scores were noted in both total and subscale scores in infants with maternal report of sleep problems.

4. Discussion

The results of this study suggest a four-factor solution for MCISQ in an internet sample of Turkish mothers with infants aged 6–18 months. The final Turkish version of the MCISQ is composed of 19 items with good reliability (alpha of 0.85). Factor structure and items included in the factors differed from the original study highlighting the cultural factors related to maternal perceptions about infant sleep or parenting behaviors.

Original MCISQ has been suggested to discriminate the mothers who were particularly distressed due to their infant sleep habits regardless of the presence of a clinical sleep problem [11]. We did not objectively define infants with sleep problems in this study, but our results support this suggestion since we observed the highest scores in infants with a small sleep problem and not in those with a severe sleep problem according to maternal perception. This again underlines the importance of

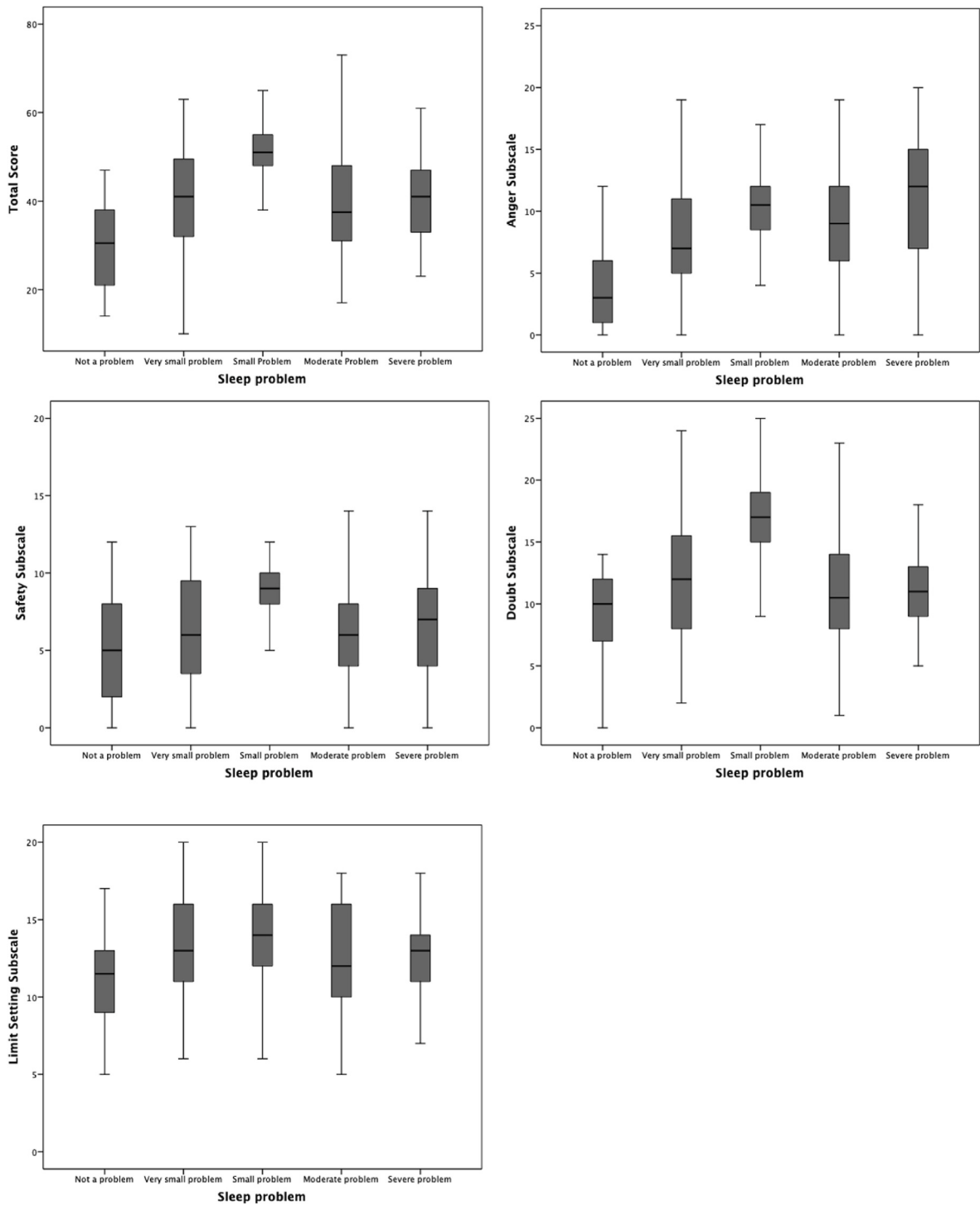


Fig. 1. Maternal cognitions about infant sleep scale total and subscale scores according to maternal report of sleep problem.

	Sleep problem		P-value
	No	Yes	
Anger	6.3 ± 4.4	10.1 ± 3.9	<0.01
Safety	6 ± 3.7	8.1 ± 3	<0.01
Doubt	11.2 ± 4.9	14.7 ± 4.8	<0.01
Limit Setting	12.5 ± 3.6	13.7 ± 3	<0.01
Total score	36 ± 12.4	46.6 ± 10.4	<0.01

conceptualizing sleep problems not only relying on intrinsic infant behavior but also on maternal perception and the mother-infant relationship. The perception of an infant’s night behavior pattern as a sleep problem may depend on the mother’s circumstances, such as general well-being, depression, or anxiety. High levels of maternal depressive symptoms combined with infant negative affectivity were associated with a greater degree of maternal perceived infant sleep problems, independent of infant sleep duration or night awakenings [17]. Likewise, maternal depressive and anxious symptoms were significant determinants of parent-perceived sleep problems in a nationally representative cohort of Turkish mothers [2].

The parental pattern of nighttime involvement shows wide variability according to culture. Few studies investigated parental nighttime practices among Turkish mothers. An important discrepancy in the studies between the Western and non-Western cultures appears in the method of feeding. Breastfeeding to sleep, commonly considered as a problematic sleep onset association in Western countries, is extremely common among Turkish mothers. In a nationally representative sample of Turkish mothers, about 75–80 % of mothers breastfeed their 6–12 months of age babies at night to sleep, and still 43–63 % of mothers breastfed to sleep their infants aged 12–24 years [2]. In the same study, although breastfeeding to sleep slightly increased the risk of parental perceived sleep problems, exclusive breastfeeding was longer in infants breastfed to sleep. In another study, cued care nighttime involvement was associated with sustained breastfeeding [18]. Of note, factor analysis revealed no feeding scale in the Turkish version of the MCISQ, unlike the original scale. Instead, feeding items appeared in the doubt and safety subscales. It may be possible that Turkish mothers with young children perceive breastfeeding as a usual nighttime childcare practice extending beyond just hunger relief, and therefore, concerns about feeding are likely to be expressed in doubt and safety subscales.

The cross-cultural differences in parenting behavior and infant sleep ecology have previously been studied [19,20]. Compared to parents from Caucasian countries, parents from Asian countries are more likely to be involved in sleep initiation of their children and interact with their children following night wakings and only few children from Asian origin can fall asleep independently. These findings were interpreted as a reflection of cultural differences in parenting styles and parent-child interaction. Common nighttime parenting practices in Turkish families need to be elucidated in further studies to understand the different factor structures of the Turkish version of the MCISQ. Turkish parenting behaviors may partially explain the differences. For example, items 8 and 14 were included in the anger subscale of the Turkish version instead of the doubt subscale of the original version. The emotions related to the anger subscale may be perceived by Turkish mothers as self-anger or anger related to parenting competency. In Turkish families, the general attitude towards infants includes protectiveness and restriction of autonomous activity with limited discipline while they are highly valued in the same time [21]. This may affect limit setting parenting behavior at nighttime. In addition, in the Turkish family system, it is still believed that the responsibility of child care is predominantly on the mother [22]. This may cause feelings of guilt about parenting in challenging situations, such as nighttime awakenings.

The MCISQ total and subscale scores have no cut-off values, but the higher scores indicate more concerns and doubts about infant sleep and related subscales. The total (46.0 ± 12.6) and subscale scores of this study sample appeared higher than in other studies conducted in diverse cultural groups [11,23,24]. In the original study of Morrell J., the mean total score was 29 ± 13.6 . This again highlights the maternal sleep-related cognitions influenced by cultural effects on young children's sleep patterns and sleep ecology [8,25]. In the original scale development study, children with sleep problems, both maternally reported as well as objectively defined, had higher total scores and limit setting, anger, and doubt subscales. Differently in our study, children with maternally reported sleep problems also had higher scores in the safety subscales. Cultural influences play a significant role in MCISQ scores as demonstrated in the study of Zreik G et al. [24]. In their study, Arab mothers were more likely to have difficulty in limit-setting behaviors, whereas Jewish mothers were more likely to report feelings of doubt and anger related to infant sleep, which was attributed to coming from a traditional collectivistic background. Although Turkish culture can be identified rather with collectivistic norms than individualistic features, as in Western cultures, ongoing changes within family and population contexts may exist, which might result in mixed behavior patterns in child-rearing practices influencing maternal response to infant night awakenings [21]. Further research exploring the link between parental practices within the sociocultural context is necessary to

develop pediatric sleep interventions for Turkish families.

The study has several limitations. First, the questionnaire was administered online, which might result in overrepresentation of the higher educational level. Even though the distribution of the educational levels of the mothers is similar to a nationwide study about young children's sleep patterns, generalization of findings is limited, specifically for the least educated mothers in rural areas with limited internet access [2]. Second, the presence and degree of sleep problems relied on maternal reports and not on the criteria that consider night awakenings, total sleep time, and duration of nighttime awakeness or actigraphy-derived sleep measures, though the maternal report is regarded as a critical determinant in assessing infant sleep problems [4]. Third, convergent validity was not measured since there is no similar questionnaire in Turkish measuring parental perception about infant sleep. Lastly, the original scale was developed to measure maternal perception and was not administered to fathers. However, paternal involvement in infant sleep is increasingly investigated in recent studies [26,27]. There is a need to measure paternal behavior and perception of infant sleep in Turkish fathers for a detailed exploration of infant sleep patterns and problems in the cultural context.

In conclusion, MCISQ has a good internal consistency, and the 19-item Turkish form is valid with a four-factor structure to be used in Turkish mothers in order to understand maternal cognitions related to infant sleep. Future studies are needed to explore paternal cognitions related to infant sleep. Culturally accepted parental infant soothing behaviors should be considered in assessing and managing infant sleep problems.

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Hatice Ezgi Baris: Conceptualization, Methodology, Resources, Formal analysis, Writing – original draft. **Mahmut Caner Us:** Methodology, Resources, Writing – review & editing, Data curation. **Perran Boran:** Conceptualization, Methodology, Supervision, Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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