Restoring the Continuum: Getting Back to the Breast

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"Society reaps what it sows in the way that infants and children are treated.

Efforts to reduce exposure to stress and abuse in early life may have far-reaching impacts on medical and psychiatric health and may reduce aggression, suspicion and untoward stress in future generations."

- Martin H Teicher

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Restoring the Continuum

- Immediate and uninterrupted skin to skin contact from birth
- 24 hour rooming-in with safe bedsharing
- Safe bedsharing at home
- ABC™ Protocol
- Exclusive breastfeeding ~6 months
- Continued BF with family foods 2+ years

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Who am I?

- LLL Leader since 1974; LLLI Board of Directors Oct 2016 ->
- Lived in 13 houses in US and Canada
- 3 now-adult BF children, 4 BF grandchildren
- Lactation consultant since before 1985; CB-Ed since 1977
- Founding role in IBLCE and ILCA, 32 years ago
- Former career in physical education, now MPH / BSOM faculty
- ILCA Board 2x; Liaison to WHO/BFHI; Code Committee
- Author of 4 professional BF texts and Sweet Sleep

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Babies need to be touched

- Skin is the baby's largest sensory organ
  - *The skin elements with the largest representation on the cortex of the brain are: hands and especially thumbs, lips, tongue, pharynx, and feet."*
    - Montagu, A. *Touching: the Human Significance of the Skin, Third Edition. New York: Harper and Row,1986*
- External gestation (Montagu) 9+ months
- Normal growth
- Enhanced dendrite formation
- Acute Skin sensitivity

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A - B - C Protocol

- ACCESS "Is the baby in the restaurant?"
  - Anyone & Everyone
  - Promotion and protection
- BREASTMILK TRANSFER "Is the baby getting milk?"
  - Basic Lactation Support
  - All Health Care Workers
- COMFORT "Is the cook comfortable?"
  - Collaboration of/with many Health Care Providers
  - Advanced Clinical Lactation Support
    - Maternal illness; infant illness
    - Complicated relationship or health issues

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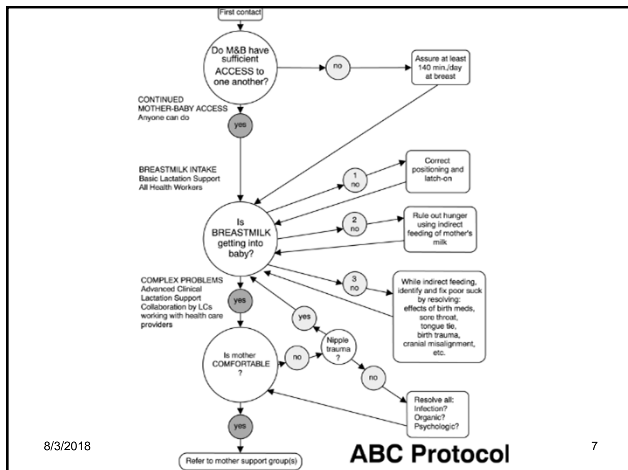

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Access: The choreography of BF

- Internal gestation > external gestation (Montagu)
- Placental life support > Lactational life support (Nylander, Odent)
- Nutrition, oxygen, arousal state, cardiac rhythms (Zeskind, McKenna)
- Sensory milieu: vision, hearing, touch, taste (Menella)
- Sensuality vs sexuality - cultural beliefs (Kitzinger, Dettwyler)

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Access: The choreography of BF

- **Anyone** can assist, support, protect
- **Attitude** is a major issue
- **Access** to the *milk* does not equal access to the *breast*
  - Direct breastfeeding
  - Feeding at the breast
  - Human Milk Feeding
- Access to mother is equally or more important
- WBW 1996 - Baby Friendly Communities

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Access: Start right

Birth	no meds	gentle	24 hr rooming in	mom in charge	BF 1st hr	doula care	colostrum
Day 1	8-12+ feeds	feels OK	stay together	meconium	1 wet		colostrum
Day 2	8-12 feeds	feels OK	stay together	2 stools?	2?? wet		milk changes
Day 3	8-12 feeds	feels OK	stay together	3 stools??	3?? Wet	weight stable/rising	milk in
Day 4	8-12 feeds	feels OK	stay together	4 yellow stools	4??Wet	weight rising	milk rising
Day 5	8-12 feeds	feels OK	stay together	3-5+ stools	many wet	weight rising	milk abundant

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Access: clinical skills needed

- Listen to the mother (!)
- Find out her goals and understandings
- Encourage, explain & educate
  - Normal babies' needs & abilities
  - "Dyad" concept, nursing anywhere, anytime
- Explore practical solutions to "access"
  - Clothing, slings, sleep arrangements, etc

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Breastmilk Transfer: Ability of infant to get milk

- Access issues must be addressed first
- Physical aspects
  - Gross motor: baby and mother postures, position
  - Fine motor: latch/position at breast
  - Oral motor: inside baby's mouth
- Coordination of suck-swallow-breathe

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Breastmilk Transfer: Ability of infant to get milk

- Evaluation: visual, auditory, kinesthetic clues
- **Visual**: mouth gape, lips flanged, little naso-labial crease
- **Auditory**: rhythmic audible swallows without clicking
  - 1 swallow per second = good milk flow
  - 2 or more sucks per swallow = low or poor flow
  - 0 swallows or asleep for long periods = no flow
- **Kinesthetic**: nipple and breast comfort without abnormal traction
- Infant self-detachment when satiated

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Breastmilk Transfer: Ability of infant to get milk

- Qualitative evaluation tools
  - Shape of mother's nipple after nursings
  - Baby's activity during and after nursings
  - Mother's report reliable - few false negatives (Neifert)
- Quantitative: pre- & post-feed weights, diaper counts
- Stooling patterns in first week of life
  - little research for days 2-3
  - Nommsen-Rivers, L. A., Heinig, M. J., Cohen, R. J., & Dewey, K. G. (2008). Newborn wet and soiled diaper counts and timing of onset of lactation as indicators of breastfeeding inadequacy. *J Hum Lact, 24*(1), 27-33.

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Breastmilk Transfer: Ability of infant to get milk

- How to help
  - Assure unrestricted access for 48+ hours
  - Correct / improve positioning and latch
  - Attempt direct breastfeeding first
  - Use equipment if direct feeding is unsuccessful
- Continue to feed the baby and remove milk, using the least complicated options for the shortest time.

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Comfort: clinical skills

- Assess / improve positioning and latch
- Breast examination
  - Visual: shape, size, symmetry, color, damage
  - Physical: weight, fullness, texture, lumps, tender areas, nipple elasticity
  - Express milk
- Psychological: full birth & lactation history
- What are mother's goals and desires?

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ABC's of Baby-Friendly Communities

- ACCESS: anyone and everyone has a role
- Legislation enables and begins changing societal attitudes
- Nutritional and health issue - health law and public policy
- Bipartisan political issue - civil and criminal law
- Women's issue - family law
- Economic and labor issue - employment law

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ABC's of Baby-Friendly Communities

- BREASTMILK TRANSFER: Basic Lactation Support
- All health care workers need brief training
- Maternal -child health workers need more training
- Mother Support Groups, peer counselors
- System structured to help at predictable crisis points
- Easy and cost-effective equipment appropriately marketed

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ABC's of Baby-Friendly Communities

- COMFORT: Advanced Clinical Lactation Support
- IBCLC credential validates lactation skills
- Collaboration and cooperation among all team members
- Clinical skills specific to lactation situations
- Costs: providers, equipment, interventions
- Costs & consequences of artificial feeding

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Principles of Problem-Solving

- Find the cause(s) before picking remedy
- Behavior issues need behavioral solutions
- Mechanical problems need mechanical solutions
- Infections need medical treatment
- Psychological issues need psychological solutions

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Designing a Care Plan

- S = Subjective - what mother tells you
  - Listening is a Major part of therapeutic approach
- O = Objective - what you find during exam
- A = Assessment - what you think is causing/ contributing to the problem; “diagnosis”
- **P = Plan for resolving the problem(s)**
- E = Evaluation - is the plan working?

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Subjective - What Mother Says

- Chief complaint - she wants this fixed!
- How she got to where she is: history
  - Name, address, number of children, health
  - This pregnancy - facts, feelings, events
  - This birth - facts, feelings, events
  - Early breastfeeding history with this baby
  - What’s going on now - facts, feelings, events
  - Her goals for this interaction/this baby/BF

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History-taking - What to Include

- Breast surgery, infections, trauma
- Abuse, abortions, eating disorders, addictions
- Active listening - reflect/validate feelings
- Really listen with empathy to her birth story
- Talk to the baby too - she’s a partner in this
- Take your time. This is 80% of the job.
- Keep going till mom has told you everything

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Objective - Your Findings

- Sanitary procedures; documentation
- Breast and nipple examination
  - Milk supply, breast configuration, damage/pain
- Baby examination
  - Overall: demeanor, appearance, posture, color
  - Weight
  - Oral area
- Observation of a complete feeding
  - Pay attention to the full 20-30 minute feed!

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Assessment – Analysis (what's going on?)

- All aspects of the mother-baby dyad
  - breast: milk supply, comfort
  - baby: ability to feed, nutritional status
  - relationship: mother's feelings about situation
- Include her chief complaint
- Include what's going well

M-B Dyad interaction

- Rhythm 40-60 suck-swallow-breathe cycles per minute
- 10-30 sucks in a burst; slight pause
- Duration ~10-30 minutes per breast
- One or both breasts per session?
  - "Finish the first side first"
  - Which is more urgent: hunger or comfort?
- Self-detachment; sleep or satiation

Look at

- Maternal nipple shape after the feed
  - Comes out WET, not distorted
  - Breast softness
- Infant
  - Satiation
  - Demeanor
  - Stools
- Time between feeds / per day

Measure / assess

- Weight and length
  - Sensitive scale used before and after feed
- Stool patterns
- Baby's mouth and general appearance
- Mother-baby interaction and "dance"
- Amount milk pumped

So….

- What is a normal feeding pattern for a breastfed baby?

Typical feeding patterns

- Day 1: first hour then many times throughout first day
- Day 2-3: every hour or so, or nearly continuous
- Day 4: patterns *may* begin to emerge
- Day 5: min. 140 min. to >250 min./day
  - Approximately hourly is typical and normal
    - Bergman, N. J. (2013). Neonatal stomach volume and physiology suggest feeding at 1-h intervals. *Acta Paediatr. doi: 10.1111/apa.12291*
- Growth occurs in spurts

Do the Math…

- A normal sleep cycle for a premature is 60 – 90 minutes
- A baby's stomach empties in 60 - 90 minutes
- Blood sugar may fall after 90 minutes

Do the Math…

- The volume of a single letdown reflex is 30 – 35 ml
- The volume of a 1-week old baby's stomach is 30 – 35 ml
- One feed every 90 minutes = 16 feeds/ day
  - 16 feeds of 30 mls each = 480 mls
  - 480 mls per day for 3 kg baby = 160 ml/kg/d
  - ***The requirement of baby.***

Feeding norms for BF babies

- # feeds *avg* **10.5** per day (wide range)
- Length *avg* **16.6** min (6.1-27.1 min)
- Intake *avg* **72** ml (4-194 ml)
- MER *avg* **60-120** sec (0.5-3.5 min)
- # MER's *avg* **2.2** per breast per feed
- Intake per MER *avg* **35** ml
- *Ref: Hartmann, Mitoulis, Daly, Kent, Ramsey & other researchers at University of Western Australia in Perth*

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Adults eat frequently, too…

- Adult REM – NREM sleep cycles every 90-110 minutes
- Adults have an urge to eat about every 90 minutes
- *Most adults aren't trying to double their weight in 6 months*
- *How do you feel when you're hungry??*

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Restoring Direct Breastfeeding

- Assure unrestricted Access for 48+ hours
  - Correct positioning and latch: gross, fine, oralmotor
  - Self-attachment
  - Try direct breastfeeding first
  - Use equipment if direct feeding is unsuccessful
    - One technique / device to collect mother's milk
    - One technique / device to feed the baby
- Continue to feed the baby and remove milk, using the least complicated options for the shortest time.

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Warning signs

- Pacifier use
- Spaced-out feeds (>3 hours routinely)
- Mom delays feeds
- Crying
- Few stools or wet diapers
- Unhappy, sleepy, worried demeanor or behavior
- Supplementation and/or nipple pain
- Very long >30 min. feeds routinely

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Social factors

- Husband/partner
- Woman's parents
- Father's parents
- Visitors (including relatives)
- Social norms
- Cultural expectations

Plan - What to do about problem(s)

- Address her chief complaint first
  - Then prioritize recommendations
  - She can only address about 3 things today
- Include all aspects of the dyad
  - Feed the baby: how, how often, with what
  - Breast care: specific details
  - Relationship: Hold baby, massage, etc
- Mother says what's do-able for her

Coach Smith's Rules

- Rule #1: Feed the Baby
- Rule #2: The Mother is right
- Rule #3: It's her baby
- Rule #4: Nobody knows everything
- Rule #5: There's another way

On-site immediate care (within 1 hr)

- Feed the baby
  - Reinforce/modify/correct positioning & latch
  - If unsuccessful at breast, feed EBM with cup
  - Guesstimate: 1 oz per hour
- Care for the breast
  - Collect milk to relieve stasis & feed baby
  - Support milk production
  - Treat edema; begin wound healing
- Support / encourage the mother
  - Find something she's doing very well, reassure

Short-term plan (next 2-3 days)

- Three issues to address
  - Follow for next 1-3 days, then re-evaluate
- Equipment/techniques needed
- Expected results of plan for mom & baby
  - Create a Plan B if this isn't working quickly
- Danger/warning signs
- Keeping in touch

Evaluation

- Follow-up call and/or visit
- What worked, what didn't
- Make changes as needed
- Follow-up as needed
- Come to Closure on this case
  - Reporting / documentation

Documentation

- Why you did what you did
- If you deviated from standard care (why?)
- Document all client contacts
- Legally required for all providers
- Many forms available, or make your own
- Form good habits

Summary

- Systematically investigate all aspects
- Counseling skills interwoven with care
- S. O. A. P. E. method
- Plan must address her problems
- Mutual contract between mother & helper
- Documentation is legally required

General plan for restoring BF

1. Feed the baby! Early and often!
2. Support milk production
3. Work on the specific problem(s)

- Close follow-up
- Evaluate need for further interventions

Breastmilk Transfer: clinical skills

- Positioning
  - Mother comfortable; pillows & props
  - Baby aligned & supported, airway open
  - *Support the breast ??*
  - “Re-boot the baby”
  - Semi-reclining / laid back
- Latch
  - Baby-led: first strategy
  - Symmetric vs asymmetric

Gross motor: mother’s position

- Assure safety (including privacy)
- Posture may matter
  - Comfort for mother, whatever that means
  - Semi-reclining or reclining may help
- Start with skin-to-skin
- Ventral-to-ventral (heart to heart)
- Baby leads; mother helps

Gross motor: baby’s position

- Skin-to-skin!
- Early feeding cues (don’t wait for cries!)
  - hands to mouth, hand passing mouth
  - Rooting, groping, mouthing, pecking
- Let the baby self-attach
- Maintain open airway
  - Support head/neck – “Make a second neck”
  - Lead with chest and chin (asymmetric)

Fine motor: latch "technique"

- Breasts remain in natural position
- Facilitate baby self-attachment
  - Mother guides baby gently
  - May bob, squirm, throw self over
- Comfortable for mother & baby
- "HOT" technique (keep your hands off!)
- ***NEVER FORCE BABY ONTO BREAST***

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Coaching tips

- Position your head lower than mother's
- Quietly observe an entire feed
- Point out effective patterns
- "Pretty good" is OK, unless painful
- "Three strikes & you're out"
  - If painful, break suction quickly
  - Try something different
- Follow the baby's pace

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Oralmotor: Inside the mouth

- Check for comfort – ***ask mother!***
  - *She WILL feel stretching and sensation*
- "100% comfortable and pleasant"
  - Lips flanged out (lower is often hidden)
  - Chin touching or pressed into breast
  - Wide gape (>120-160° angle of jaw)
  - Full rounded cheeks
- Observe changes in suck rhythms

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Breastmilk transfer: Clinical skills

- Assess suck-swallow-breathe
  - Smooth ratio of suck-swallow-breathe
  - 10-30 cycles; brief pause then resumes
  - Duration ~10-30 minutes per breast
  - Self-detaches in obvious satiation
- Nipple shape after baby detaches
  - Nipple should come out wet, not *bent*
- Select / recommend equipment use

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Principles of equipment use

- First, do no harm
  - Direct breastfeeding is the norm
- Obtained informed consent
  - Device(s) if not the breast
  - Fluid/food if not mother's own milk
  - Who uses the device(s) if not mother
- Least intervention for shortest time
- Goal: establish or restore direct BF

Social vs therapeutic uses

- Therapeutic – for a specific clinical goal
  - Requires critical thinking
  - Requires clinical judgment
  - No "one best" method
- Social / casual
  - "Cookbook" approach
  - Consequences not considered
  - "slippery slope" concept

Devices to collect/obtain milk

- Baby
- Hand-Expression
  - Mimics tongue peristalsis
- Pumps
  - Mimics oral negative pressure
    - 100-250 mm hg negative pressure
    - 40-60 cycles per minute

Devices to feed baby

- Breasts
- Mother using a device
- Someone else using a device
- External (outside the mouth) devices
  - cups, spoons, bowls
- Internal (inside the mouth) devices
  - teats, tubes, syringes, "fingerfeeding"

Alternate Feeding Methods

- All are "interventions"
- Identify the problem before picking a device
- Know the drawbacks/risks of devices
- Non-invasive devices: cups, spoons
- Invasive devices: teats (bottles), tubes
- No "best" method if BF isn't possible

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Outside-the-mouth devices

- **Easy to clean**
- Long history of use
- May be less threatening to aversive babies
- Recommended worldwide
- May encourage better tongue peristalsis

- May have more spillage
- Risk of aspiration
- Risk of too-fast feeds
- No sensory input to palate
- May not trigger suck response
- **Best-researched**

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Inside-the-mouth devices

- Long (bad) history of use
- May help organize baby
- Sensory input to palate and inside of mouth
- May trigger suck response
- Less spillage

- **Hard to clean**
- More expensive
- Teats: risk of too-fast feeds
- Risk of "confusion" and mispatterning
- May threaten aversive babies
- **Not fully researched**

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How to select the device

- Carefully analyze the baby's problem
  - Sensory?
  - Motor?
  - Neuro/chemical - birth medications?
  - Insults, injuries, procedures?
- Try a cup first
- Consider mother's wishes/preferences
- Re-evaluate in 24-48 hours
- Modify/change as needed to restore BF

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Give specific suggestions

- Access: Get naked with baby for at least one hour, at least twice each day
  - Hold & carry baby as constantly as possible
- Breastfeed: Try BF every time baby cues
  - Feed 1-2 ounces of your milk every 1-2 hours using a small cup, try BF again after cup feeding
  - Baby may sleep up to 3-4 hours ONCE a day
- Comfort: express milk till drops stop after 2 let-downs every 2-3 hours, or when breasts feel 2/3 full, whichever is sooner
  - Express fully (to "empty") at least once a day

Give expectations

- **Access**: expect baby to wake & eat every 60-90 minutes, with one sleep stretch
  - Expect baby to be more alert as he eats more
  - Don't use a pacifier – feed again!
- **Breastfeed**: gradual improvement, more wet and full diapers each day
- **Comfort**: collect more milk each 24 hours (count day's total, not each batch)

Follow up & Document

- 2-3 days after initial assessment *in person*
  - Do more of what's working
  - Change what isn't working
- Again in about 1 week – *in person*
- As long as needed – until:
  - Baby and mother are smoothly breastfeeding
  - Mom gives up – help her wind down
- Referral to ongoing support (Step 10)

Nursing at the breast is more than getting milk

- Fat level variations trigger satiation
- Spray-cleans entire oral / nasal cavity
- Release of gut hormones, insulin, oxytocin
- Interrelated with breathing and swallowing
- Nipple tip placement stimulates pituitary
- Facial & dental structural development
- Airway patency; affects sleep patterns
- Eye-hand coordination and reading ability
- Trust and autonomy

Eventually most babies do BF

- Most can BF well by 40-44 gestational weeks
- Cranial molding should resolve by 1-2 weeks
- Drugs mostly wear off by 4 weeks
- Injuries should heal by … ?

- IF NOT – investigate further & collaborate

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What if all this doesn't work?

- Medical/clinical issue in the baby or mother
- Persistent feeding problems may indicate other and serious underlying problems
- Persistent low milk production may indicate other underlying problems

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Manipulative & other therapies

- Kangaroo Care and Infant Massage
- Rebirthing / repatterning
- Therapeutic massage
- Osteopathic Manipulative Therapy (OMT)
- Cranio-sacral therapy
- Speech and Oral-motor therapists
- Fascial release, similar bodywork (PT, OT)
- Pediatric chiropractic therapy
- *How to find / work with a therapist*

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The bad news ☹

- There is no "quick fix" or nifty trick for babies who are injured, drugged, or compromised by birth practices and cannot breastfeed
- Mothers blame themselves
- **Need**: Team-based assessment & care of all infants who do not BF easily and quickly after birth
  - Assertive support of mother's milk supply
  - Feeding devices / techniques that support BF
- **Need**: Documentation and research

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The good news ☺

- Breastfeeding is increasing in popularity and importance globally
- "Birth practices affect breastfeeding" is not a new concept – BFI now includes
- Research is adding to our skills and knowledge
- Major health organizations and policy statements now support breastfeeding
- Babies are born to breastfeed!

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Lastly, Implement Step 10

- Proactively help mothers find peer-support networks and mother-support groups
- La Leche League
- Other support groups/systems
- Peer Counselors / Helpers
- Assure ongoing pediatric health care

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Summary – Restoring the Dyad

- Immediate and sustained skin-to-skin contact after birth
- 24-hour rooming in with safe bedsharing
- Screen for problems with ABC Protocol
- Medical & clinical follow up
- Stick with the mother as long as she needs your support
- Help her access support systems

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Our job: Smoothing the way

"Smoothing the Way"
Composed and performed by Zoe Mulford
For ILCA's 25th anniversary 2010

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