Helping with a Breastfeeding

Assessment Techniques and Simple Corrective Strategies

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ABSTRACT

In session #3, we learned that the transfer of existing milk is critical to the making of more milk. But when observing or helping with a feeding, how will we recognize when milk transfer occurs? How will we help the couplet when milk transfer is questionable or compromised? How is all of this related to the mother's often-expressed concerns about not having enough milk? The goal of this learning program is to help the learner to develop targeted assessment techniques and simple corrective strategies to assist the mother-baby couplet to independently achieve optimal latch and milk transfer in the first few days of life, even in situations where anatomical or behavioral issues impede optimal milk transfer.

BFHI Related Step

Step 5

Objectives

- Relate the three phases of social interaction to observable behaviors that facilitate or undermine the breastfeeding experience.
- Distinguish between the newborn's signs of approach and signs of avoidance.
- Classify signs of hunger as early or late indicators of hunger.
- Recognize clinical indicators of effective and ineffective latch and milk transfer.
- Review indicators and consequence of poor latch and ineffective milk transfer.
- Identify principles for observing and assisting with a breastfeeding.
- When observing a breastfeeding couplet in the approach, interactive, or satiety phase, distinguish between reassuring and worrisome indicators that breastfeeding is going well.
- Describe techniques to help (if needed) the mother-baby couplet to achieve optimal latch.
- Choose a general strategy to resolve problems associated with ineffective latch or the reluctant nurser.

Instructions

See the *ReadMeFirst* document in your account.

Materials and Resources

Post-test items that are similar to those found on a certification exam.

Vocabulary

Signs of Avoidance
Signs of Engagement

Criteria for Earning Credits

See the *ReadMeFirst* document in your account.

Accreditation

See the *ReadMeFirst* document in your account.

Faculty

Marie Biancuzzo RN MS IBCLC has achieved national recognition for her expertise in maternal-child nursing, breastfeeding, and continuing education. Her profile is on LinkedIn.

Topical Outline

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Questions for the Author/Presenter:

Write your questions here!

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Email us at info@breastfeedingoutlook.com if you have questions. Telephone is not as efficient, but you are welcome to call us at 703-787-9894.

II. Introduction and Overview

A. Social Interaction and Observable Behaviors

1. Uvnas Moberg: Three Phases of Social Interaction
   - a. Approach (Hunger)
   - b. Interaction
   - c. Satiety
2. Observable Behaviors
   - a. Sleep/wake states
   - b. Behavioral States (Approach vs Avoidance)
   - c. Signs of Hunger and Satiety

B. Goal of "Helping" with a Feeding

1. Facilitate *feeding* when the Approach phase occurs, or facilitate the occurrence of the Approach phase. The latter can be easily accomplished by skin-to-skin contact.
2. Some studies use the terms *suckling* and *skin-to-skin contact* as interchangeable or synonymous, whereas others[1-3] make a clear distinction between contact and suckling.

III. Communication: Reading and Responding to the Newborn's States, Behaviors, and Reflexes

A. Uvnas-Moberg: Three Phases of Social Interaction

1. Approach Phase (a.k.a. Hunger Phase)
   - a. All Five Senses are involved in the Approach phase
     - (1) Seeing
       - (a) Visual acuity is best at about 12-18 inches away.
       - (b) Like light and dark geometric shapes the best.
     - (2) Hearing
       - (a) Babies respond best to their mother's voice
       - (b) When babies are left alone, they emit a separation distress call that is similar to those of other mammals.[4]
     - (3) Smelling
       - (a) Infants have a very well-developed sense of smell, and will root toward the milk.
       - (b) Infants prefer the smell of their mother's milk to infant formula[5]
       - (c) Odors that overpower the mother's milk may be a deterrant to breastfeeding.
     - (4) Tasting
       - (a) Mother's milk tastes sweet, because of the high amount of carbohydrate in human milk

(b) Babies like a sweet taste! (Don't we all?)

(5) Touch

(a) Skin-to-skin contact is enormously important!

(b) Skin-to-skin contact is a way to approach the breast, the food, the mother!

(c) More on this in Session #7

b. Normal Feeding Cues (Approach aka Hunger Phase)

(1) Parents' Expectations, Interpretations

(a) Parents must learn to identify and respond to early hunger cues.

(i) Parents need to respond to early hunger

(ii) They often wait until infant cries; crying is a *late* sign of hunger

(b) Parents also need to identify signs of *satiety*.

(c) Use good a/v aids

(2) Parents Observations of Hunger Cues

(a) Sometimes, infant has subtle signs of hunger

(i) Likely situations

(ii) How to recognize

(b) Practices that mask hunger signs

(i) Tight swaddling

(ii) Pacifiers

(iii) Separate sleeping rooms!

2. Interaction Phase

a. Indicators of Good Latch for Newborn

(1) Alignment (positioning of mother and baby)

(a) Baby's head and body are in a line.

(b) Mother holds baby's body close to hers.

(c) Newborns need whole-body support (not just head and shoulders)

(d) Baby should face the breast (baby's nose opposite the nipple) .

(e) Do not push baby's head into the mother's breast. (I call this "screwing the baby's head on.")

(2) Areolar Grasp

(a) Open wide!

(b) Lips flanged outwards

(c) Complete seal

(d) Approximately ½ inches of areolar in mouth

(e) Tongue is troughed and extends over lower alveolar ridge

(3) Areolar Compression

(a) Mandible moves in rhythmic motion

(b) Wave-like movement of tongue

(4) Audible Swallowing

(a) Lack of audible swallowing ALWAYS deserves follow-up.

(b) Always listen for SWALLOWING!

b. Indicators of Poor Latch

(1) Absence of any of the "good latch" indicators

(2) Lips & Mouth

(a) Lips flanged too far back

(b) Cheeks are puckered in

(c) Angle of the gape is less than 120º

(3) Head, Chin, and Neck
  (a) Head is not free to move
  (b) Chin does not indent the breast
  (c) Neck is hyperflexed or hyperextended
  (d) Head is turned rather than straight-on
  (e) Non-alignment of "nose-to-nipple"

(4) Other Indicators
  (a) Clicking sound
  (b) No "changing gears"
    (i) short fast bursts to…
    (ii) long, slow, rhythmic bursts and eventually…
    (iii) short, fast bursts

3. Satiety Phase
  a. Baby takes himself off the breast
  b. Absence of hunger cues
  c. Babies who continue to suck for long periods of time are likely to not be taking in milk and will NOT be satiated.

B. Sleep/Wake States

1. Deep sleep
2. Light Sleep
3. Drowsy
4. Quiet Alert
5. Active Fussy Alert
6. Crying

C. Behavioral States: Approach vs. Avoidance

1. Signs of Approach ("Organized Behavior")[6]
  a. Tongue extension
  b. Hand on face
  c. Hand clasp, or hands touching, or hands to body
  d. Foot clasp (feet against each other, or crossed)
  e. Body tuck
  f. Hand-to-mouth attempt (does not have to succeed)
  g. Mouthing movement
  h. Suck-search

2. Signs of Avoidance ("Disorganized Behavior")[6]
  a. Yawning, grimacing
  b. Sneezing
  c. Hiccoughing
  d. Spitting up
  e. Sighing

f. Coughing

g. Airplaning

h. Finger-splaying

D. Signs of Hunger and Satiety[1]

1. Hunger and Satiety

a. Signs of Hunger[7]
- (1) Rooting
- (2) Suckling Motions
- (3) Motor activity: hands-to-mouth, flexion of arms, legs moving as though riding a bicycle
- (4) Posture/affect: tense; clenched fists
- (5) Crying: note that this is the *last* sign of hunger

b. Signs of Satiety[7]
- (1) Audible swallowing during feeding
- (2) Cessation of audible swallowing; increased nonnutritive sucking and longer pauses between sucking bursts
- (3) Infant takes himself off from the breast, rather than being taken off
- (4) Disappearance of hunger cues
- (5) Posture/affect: arms and legs relaxed, drowsy
- (6) Sleeping
- (7) Sucking

2. Readiness: Indicators of Readiness to Feed

a. Showing signs of optimal sleep state

b. Exhibiting signs of engagement

c. Helping Baby to Become Ready to Feed
- (1) Skin-to-skin contact
- (2) Mother and baby approach one another in a way that has interaction. Skipping this phase and going directly to feeding is not desirable or useful. This is a dance!
- (3) Helping baby to find her fist
  - (a) calms a fussy baby
  - (b) provides perioral stimulation to alert a sleepy baby

3. Indicators of Disinterest or Refusal

a. Not Ready to Start, or not willing to continue
- (1) Sleep/wake states
  - (a) A hungry baby will not sleep
  - (b) A sleepy baby will not eat!
  - (c) An overly-hungry, frantic baby will not eat
- (2) Signs of Avoidance (disengagement, disorganization)

b. Signs of Refusal
- (1) Latching briefly then pulling away
- (2) Arching back
  - (a) May be an out-and-out refusal

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[1] See Marie's full-color photo-illustrated parent handout on this topic.

(b) May be just that baby needs to burp!

(3) Latches but does not suckle after latch

(4) Goldsmith's sign is when the infant consistently refuses one breast; this is a possible sign of breast cancer.[8] See Biancuzzo[7] pages 132-133; Gentilini article.[9]

IV. The Assistive Role: Principles for "Helping"

A. General Guidelines

1. Introduction and Greeting (Maternal aspect) Ask the mother if you can watch "the baby" breastfeeding (not "you")
2. "Introduction" to baby (Newborn aspect) Perioral area is the most sensitive part of baby's body. Stimulating the lips, gum, tongue may be key to awaking the baby's interest in suckling.

B. Sequence and Judgment: When to "Help"

1. Observe before "assisting"
2. Not always easy to tell
3. Do not "take over"

C. Positioning

1. General principles of positioning
2. Mother's Hand Positions
   a. V-hold
   b. C-hold
   c. U-hold
   d. Dancer hand
3. Commonly-used positions for the newborn
   a. Cradle or "Madonna"
   b. Side-lying
   c. Football (clutch)
   d. Less-common positions
      (1) Straddle hold
      (2) Others
4. Comparison of Basic Positions[7] p. 155
   a. Advantages
   b. Limitations
   c. Pertinent Points

D. Touching vs Not Touching

1. If you must touch, ask permission.

2. "Touch" by moving the mother's hand or arm, not her breast

E. Counseling and Evaluation

1. Tell the mother what you are observing
2. Always find something positive to say!
3. Make sure mother understands the process
4. Demonstration, return demo, encouraging words
5. Notice how mother is responding to suggested changes
    a. Verbal: ASK her how it feels, seems, etc.
    b. Notice her non-verbal behavior, too

V. When Suckling Is Not Spontaneous or Sustained

A. Slow or Delayed Adaption to Extrauterine Life

1. Indicators of Slow or Delayed Adaption
    a. Unstable vital signs
    b. "Hypoxic Stare"
    c. Sleepiness
    d. Sluggish "other" reflexes
2. Possible Adaptation Reasons for Difficult or Reluctant Latch
    a. Labor-related: long labor, low oxygenation during labor, etc.
    b. Meds that can depress reflexes including analgesia and $MgSO_4$
    c. Complicated delivery, including vacuum
    d. Birth trauma, including caput succadaneum, hematoma, brachial palsy, Bell's palsy, fractured clavicle
    e. Unexplained phenomenon that are often diagnosed later, including torticollis.
    f. Serious congenital issues, e.g., cardiac anomalies, chromosomal anomalies, etc.

B. Difficult Latch: Anatomical Reasons

1. Anatomical Variations (Maternal)
    a. Large breasts and/or large areola
    b. Large nipples
    c. Short or flat nipples
    d. Long nipples
    e. Inverted nipples
    f. Dimpled nipples
2. Anatomical Variations (Infant)
    a. Baby has small mouth

b. Tight frenulum

c. High-arched palate

d. Flat philtrim

e. More serious pathology, e.g., clefting, torticollis, fractured clavicle, facial palsy, and more.

C. Special Techniques

1. For Muscle Tone

a. Providing More Support: Hypotonia
(1) Straddle hold
(a) (My O.T. friend emphasizes "proximal stability to improve distal mobility")
(b) I like straddle hold for hypotonia
(2) Transitional Hold
(3) Dancer Hand

b. Hypertonia: Reducing Tension of Mandibular Muscles

2. Overcoming Issues with Anatomical Variations

a. Rolled up washcloth for large breasts

b. "U" shaping for large areolae

VI. Management of Reluctance to Feed

A. Remove or Treat the Cause

1. Unsuccessful Latching and/or Transfer

a. Suggest repositioning of mother of newborn, as needed

b. Suggest expressing a little milk if milk is coming too fast, too slow, or nipples are short and breast is engorged.

2. Related Issues

a. Medical issues or pain
(1) See if mother or baby needs medical attention, i.e., baby has sore mouth from thrush, or mother has sore nipples/breasts.
(2) Watch for sources of pain: baby's head is bruised, mother has "sore bottom" and needs to be repositioned, etc.
(3) Suggest pharmacologic pain relief if needed.

b. Avoid artificial teats or pacifiers.

c. Check on things that are "turn-offs" for baby, perhaps something as simple as mother's perfume.

3. Alerting and Consoling Techniques[10]

a. General Techniques

b. Alerting Techniques[10]
(1) Eye contact
(2) Changing diaper
(3) Speaking, singing, humming
(4) Stroking head *against* hair growth

(5) Skin-to-skin contact!!!!
(6) more

c. Consoling Techniques[10]
(1) Carry, rock, swing
(2) White noise
(3) Holding, “nesting”
(4) Stroking head *with* hair growth

B. Prevention of Cause

1. Skin-to-skin contact, early and often!
2. Help mother when things are calm and unhurried
3. Exhibit and encourage patience
4. Show confidence, compassion, gentleness
5. PRAISE the mother, even if it means praising her for non-latch behaviors!

VII. Summary

- Recognizing and responding to the three phases of social interaction is critical to helping with a breastfeeding.
- Observing a breastfeeding entails observing not only the baby’s ability to latch and transfer, but also, the mother’s comfort level and any related difficulties.
- With minor issues, “helping” is in order; interfering is not. Couplets who are experiencing difficulties need more active help.

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Optimal Alignment

Infant flexed and relaxed	Muscular rigidity	Use comforting and calming techniques
Head and body at breast level	Head and/or body sagging; baby reaching for breast	
Head squarely facing the breast	Head turned: Laterally Hyperextended Hyperflexed No “tummy-to-tummy”; trunk is facing the ceiling, not the mother	
Infant’s body aligned from shoulder to iliac crest	Infant’s body unaligned	

Areolar Grasp

Angle of the mandibular gap is about 120-130º	Angle of the gape is less than 90º	
Upper and lower lips flanged outward	One or both lips not flanges One of both lips curled inwards One or both lips are flanged too far back	
Complete seal formed around areola; strong vacuum		
Approximately 1½ inches of areolar tissue is centered in infant’s mouth		
Chin indents the breast	Chin does not indent the breast	
Cheeks are full and rounded	Cheeks are “puckered” in	
Tongue is troughed	Tongue is flat	
Tongue extends over lower alveolar ridge	Tongue does not extend over lower alveolar ridge	
	Often occurs when infant does not have a wide-open gape	

Areolar Compression