ATTACHMENT: THE ART OF COMFORT CARE

Kittie Frantz, RN, CPNP-PC

Objectives

1. Describe the anatomy of the breast and baby's mouth and how they work together
2. Walk through the evolution of holding the baby as it progressed through many methods of attachment
3. Discuss the many methods of holding the breast and attachment as it evolved through the years – each expert adding more to the knowledge
4. Name two ways baby led and laid back breastfeeding appear to be the culmination of all of the attachment methods
5. Discuss effective ways to assist the mother in working with her baby in attachment
6. Name two ways to breastfeed in bed
7. List 4 ways to evaluate nutritive suckle/swallowing at the breast
8. Discuss what you learned from the role paying scenarios

I. Introduction

A. Mother as well as baby needs to be comfortable breastfeeding

B. Historical overview of how attachment advice has evolved

II. Anatomy Principles. What do we know?

A. Attaching to only the nipple hurts

B. Babies nurse the areola – the darker area behind nipple

C. Baby compresses areola with his jaws as the….

D. Tongue reaches forward with tip & draws in breast to form a teat (Ardran)

E. Tongue rolls back & upward to "milk" the teat

a. Under 4 months tongue rolls up & back (Woolridge)

b. Over 4 months the tongue moves upward

c. Try this with your own finger to see if it is so

F. What happens when tongue stays behind the nipple?

G. Review of the three phases of the suck

H. How does baby know to asymmetrically latch?

a. Montgomry's glands as a scent gland?

b. Cream covering the Montgomry's glands pose a problem?

I. Babies can do this when they have medical problems if they use the tongue correctly (i.e. cleft palate) or if mom has flat nipples.

J. Back of tongue downward is the negative pressure causing milk flow

K. What we don't know.

a. Hartman group disputes existence of sinus beneath areola

b. Ducts widen as milk flows down lactiferous ducts under the areola –same process?

L. Baby's mouth placement - tongue under areola makes sense

III. Holding the Baby

A. Used to lay baby on his back on the bed

1. Often mom was handed the baby with no help to attach him

2. This was hard on baby to reach and attach deeply to the breast

3. Tickle cheek (rooting reflex) to turn head toward the nipple made it difficult swallowing

B. Dr. Applebaum said 45˚ angle for baby on his side

1. Best for babies bothered by reflux

2. Baby faced the breast with his head in line with his body

C. Progressed to tummy to tummy baby to mother

1. Legalism began

1. Absolute on side & whole body facing mom

2. Every part of baby had to face mom

3. Began to measure angles of the baby and mom

2. Royal College Midwives & Gunther (1940's) said baby slightly rolled back for eye contact

1. Realized if baby totally facing mom, he attached to upper areola

2. If head slightly tipped back, he attached to lower areola

D. Many of the methods we taught were to try and avoid sore nipples

E. Elsa Wood – of New Zealand

1. Knees against mom important too

2. Knees touching mom's body cleared the airway as it changed the angle of baby's face to the breast.

F. Wood & Gunther's ideas became important

G. Jack Newman agrees using cross cradle hold

1. Supported occiput, shoulders & neck

2. Provided stability to the baby that helps suckling in some

H. SO WHAT DID WE CONCLUDE???

a. Baby is on his side

b. This is called "dorsal feeding"

c. Diaper snug up against Mom

d. 45 degree angle nice for baby

I. Pillows

1. Interfere with 45˚ angle as baby often laid flat
    1. When mom holds the baby w/o pillow, he is more angled upright
    2. Office chairs tilt back, arms adjust, & it lowers so feet are flat on the floor.
    3. Baby sits on her thigh without the pillow
2. Difficult if Mom has short torso – baby too high on the breast
3. Difficult if mom has long torso – leans over baby or raises knee
4. Baby often lays more toward his back – dorsal feeding
5. Elbow support is nice – throw pillow, couch arm rest
6. May need a foot stool
    1. Pitches her back for comfort
    2. Uncomfortable if feet don't touch the floor
        a. Pillows on the floor
        b. Office chair adjusts so feet flat

IV. The Attachment Process What has happened to the latch?

A. Holding the breast

1. Just nuzzle close to nipple was first suggested
2. Then came "grasp nipple in fingers & insert it into baby's mouth"
3. "Scissors" hold changed to "C" hold
    1. Misplaced index finger can cover the lower areola

2. She can't see her fingers under the breast looking down
3. Placing her hand flat on her rib cage & moving it up to the breast prevents that

B. Getting Baby's mouth to open. How do we get baby's mouth open?

1. Cadwell says touch nose to nipple
2. Newman says slide nipple over upper lip
3. Renfrew & Fisher says brush both lips
4. Cox says touch areola to lower lip
    1. Can she see her lower areola?
    2. Concept absolutely correct but hard for mom to use
5. Frantz says touch lower lip to elicit rooting reflex
    1. Touch upper lip and baby will open
    2. Touch lower lip and baby opens wider with groove in center of the tongue
6. Infant reflexes say lower lip – anticipatory phase of the suckle
    1. Jaw drops
    2. Tongue lowers & curls at the tip
    3. Head tilts back slightly
    4. When baby does this at the breast, it puts him on the lower areola
7. Righard says let them find it – baby buts his chin on her breast, opens his mouth and attaches

8. Smillie say baby anchors chin and lower lip to breast & opens his mouth

C. Starting the sucking to draw the breast into the mouth

1. Marmet says the "S" spot on the palate triggers suckle.
2. But reflex study sees another step before that.
3. Part two of suckle reflex is the simultaneous touching of inner lips
4. The "S" spot may assist in "sustaining" the suckle
5. The 3rd baby in Righard's film "Delivery Self Attachment" shows this in sequence

D. Inverted nipple? OK if baby can compress the areola

E. Flat nipple? OK but may be temporary due to surgical muscle relaxant

F. Birth practices can interfere with how baby negotiates this

1. Center for Disease Control (CDC) mPinc survey looked at this
2. Smith & Kroeger book ("Impact of Birthing Practices on Breastfeeding") goes into detail
3. Trust & safety issues for mom & how the doula works with that
4. What is instinct?
5. What are the risks of intervention?

G. Placement Ready, get set, …LATCH!

1. The "target" latch was first = center on that areola!
2. "Up and over" began next
3. Newman, Fisher, Frantz, Weissenger & others realized attachment to the lower areola was better – the asymmetrical latch. Why?

   a. Safer for nipple if tongue under & not on top of it
   b. Better swallows = better weight gain

4. It was noticed that as baby's jaw gapes, his head tilts back (head lifting reflex)
5. So when baby brought **straight** in, he is placed on lower areola
6. Baby-led latch – the baby does it right! (Baby-Led Breastfeeding DVD & Baby Self Attaches DVD)
   1. Asymmetrical latch
   2. Baby positions himself in a 45 degree angle
   3. Baby comes off when he is ready
   4. After burping moves to the opposite breast
7. Why do babies pause a lot while suckling?
   1. Some need to rest while coordinating suckle/swallow
   2. Some pace the feed as to not be overfull if bothered by reflux
   3. He is <u>not</u> using mother as a pacifier! He has a reason!
8. Placement of Montgomry's glands are clustered where nose will be (evidence of the scent gland theory)
9. Don't lay mom flat for self attachment
   1. Too much gravity and nose may bury in breast
   2. To hard to head lift to protect airway
   3. May fall off of mom trying to get under the long breast

4. Mom in a 45° angle allows baby to head lift in “sniffing” position

10. Glover describes a sequence of reflexes
    1. Breast touches lower face
    2. Baby opens his mouth
    3. Chin forward as tongue scoops in the breast
    4. Upper lip clears the nipple as the jaw closes
    5. Suckling begins
    6. Moms following baby’s lead prevent “up and over”
    7. Moms trying to engineer the “deep latch” may bring baby too high on the upper areola and cause soreness.
11. Compress breast like a “hamburger” work?
    1. Makes the areola firm
    2. Baby who initially bites, bites the firm areola getting a squirt of milk that starts the suckling.
12. How old a baby will self latch?
    1. Primitive reflexes are the first two months
    2. After that it may just be a learned behavior
13. Some techniques forced the head in
14. Then “Hamburger Sandwich” latch began – Weissinger’s drawings show it with the asymmetrical latch
15. Baby-led does better than “swipe down the mouth” method! (Baby-Led Breastfeeding DVD)

1. If she is sore, ask if she wants to try something different
2. Try Baby-led and if no pain, go with it
3. Moms get confused when “right” becomes “wrong”
4. Unprofessional to tell her what she was taught is wrong. Let her discover it.

16. Chloe Fisher & Renfrew said
    1. Baby drops his jaw
    2. Then bring baby’s **body** straight in close with mom’s arm
17. What do experienced moms do?
    1. Some nipples point to the floor and lay on mom’s abdomen
    2. How does baby get under it for asymmetrical latch?
    3. Mom places her hand palm on her upper breast & moves it upward presenting the lower areola to the baby.

H. Putting it all together

1. Lay him on his side in cradle hold so he sees Mom
2. Football hold on his side
    1. Hold occiput/neck
    2. Baby in 45° angle facing & touching mom’s body
    3. Twins in double football hold
    4. Can pick up one twin with the occiput/neck scoop
    5. Wrists straight if Carpel Tunnel Syndrome
    6. Baby’s hands circle the breast
3. Cross cradle/opposite hand hold prone on mom in 45° angle

4. Steps of attachment (drawings)
    1. Touch breast to lower lip/chin
    2. Head moves slightly back
    3. Bring baby straight in
    4. Asymmetric latch
    5. Lower part of baby touching

I. Laid back breastfeeding

1. Colson studied newborn reflexes & found they coordinate better:
    a. Laying back opens mother's body so baby completely prone and touching more of her body surface
    b. Which is reclined in a 45 degree angle.
    c. This includes & goes beyond Righard, Bergman, & Smillie's work
2. Mothers who got comfortable in a laid-back position nursed their babies longer.
3. Torso holding freed mom's hands for stroking the baby
4. Mom's free hand stroking changed baby's suck and created a letdown
5. Mothers nursing longer went into an "oxytocin zone" of relaxation
6. Baby stimulated the letdown by raking his fingers on the breast

J. Laid-Back Positioning

1. Delivery
    1. Mom in a 45° angle in delivery bed
    2. Baby prone
    3. Baby does head lifting
    4. Mom's hands free to stroke/caress baby
    5. Baby rests for 20 min & at breast by 50 min (Bryndir, Healthy Children "Skin to Skin The First Hour After Birth" DVD)
    6. Mom's arm makes a nest preventing baby from falling to her side
        a. Some babies may want to kneel at her side
        b. Baby is free to rotate into many positions
    7. Post partum
        a. Some moms sit up bent over baby on a pillow
        b. Laying mom back in 45° angle with baby prone on her chest makes mom so comfortable that she may let baby nurse longer!
    8. NICU
        a. Mom laid back in the office chair
        b. Baby supported by her body
        c. Works well with twins – double cradle hold
        d. Mom can still play with the feet

e. Baby rakes her breast with his fingers creating another letdown

f. Oxytocin puts mom into a blissful zone of relaxation

9. Couch at home

a. She can sit up hunched over a pillow or

b. Lay back on the couch pillows in a 45° angle

10. Chair at home

a. She can sit up holding baby resting on her thigh

b. Or some chairs recline to lay back

c. Longer feed = more oxytocin= more letdowns and a sleepy mom. Nap to rest?

11. Chaise with foot stool does the same laid-back position

12. In bed make a bank of pillows to create a 45° angle ramp for mom

V. What to Teach? Most agree to attach to the lower areola. Which method is best?

A. Keep it simple

1. How can she visualize it?
2. How do you know what you taught her worked? Doulas are there day after day
3. What kind of follow-up do you have to know this? May not go back to the same LC

4. Baby-led latch takes the pressure off of mom – baby does it

B. Prenatal

1. Make it sound easy and simple
2. Anyone can do it
3. Teach the idea only and practice with a doll
4. Show DVDs of babies self attaching – she can't wait to try it
5. Give her a handout to take to the hospital packed in her bag

C. Postnatal

1. Educational hospital TV channel may have videos
2. Lactation consultant requested?
3. Suggest she try Baby-Led attachment herself in laid back position if what she is shown is not working well.
4. Come to see you after discharge
5. Receives support at well baby visits
6. Hispanic moms lean toward "los dos" (giving formula also)
    1. Formula changes the gut flora – less illness protection
    2. Too much formula in the first week contributes to obesity

D. Watch her

1. Analyze what you see
2. Praise what is right
3. Realize yourself what is wrong
4. Ask if you can try a different idea

a. Moms think only one “right” way

b. Confused when “right” becomes “wrong”

c. She is trying the “method” she learned

d. Identify the problem her “method” is causing

e. Ask permission to try a change

5. Repetitive reinforcement Old habits are hard to break

    1. “Mommie brain” learns by repetition

    2. Teach dad or grandma along with her

    3. Significant other to help if you are gone

    4. Leave her with a handout

    5. Have dad take cell phone pictures for home

6. Follow-up

7. She is back! She bonded with your care

    1. She forgot what you taught her

    2. Home is a different setting (furniture/activity)

    3. Baby is not doing something different with the suck

VI. Reclining Positioning – Nursing in bed is female survival

A. Watch “First Attachment in Bed” video

B. Show her laid-back positioning in bed in the day to prepare for night time

VII. Caregiver assessment of nutritive suckling

A. Swallowing every 1-3 suckles?

B. Wide jaw excursions?

C. Rotary jaw movement?

D. Hear swallows with stethoscope?

VIII. The bottom line

A. Good swallows and no pain

B. Baby gaining weight

C. Baby drives the system

D. SUCK CESS!

IX. Role playing – clinical competencies –students play the role as the helper or the mom or dad

A. Sitting upright in a recliner chair with breastfeeding pillow in her lap and mom hunched over the baby breastfeeding

1. PP doula arrives
2. Students list all that is correct that mom is doing
3. Students list all that is a problem that mom is doing
4. Took baby off the breast
5. Student teaches with her hands. Great!
6. Asks mom for pain feedback

B. Different student in recliner chair using football hold with baby flat on the arm of the chair

1. Establishes relationship with the mom
2. Midwife sits to be eye level with mom
3. Asks if mom has sore nipples
4. Asks permission to try something new
5. Complements mom

6. Skin to skin on chest
7. Started to take the back pillow away
8. Feet up on stool
9. Discussion about glider vs recliner chairs & no back pillow

C. Mom and dad in bed and student the doula/helper brings the baby to them at night

1. How to handle it when dad is in the bed with mom
2. Teach mom in the day to prepare for night
3. Mom insists on sitting up and is crabby
4. Student negotiates laid-back position
5. Puts pillows at elbows and makes a “nest”
6. Finally gets head pillow right for mom
7. Student sits next to the bed on a birthing ball
    1. Level eye contact with mom
    2. Can watch mom if she wants to drift off to sleep
8. Student playing mom felt that her comfort was leading her
9. Take baby for diaper change and back to mom while mom sleeps
10. Assess swallows to monitor feed

D. Swaddled baby and the kneeling position at her side are student questions

1. Can’t get hands out of the swaddle to do head-lift to protect airway
2. Baby stiff swaddled and doesn’t shape to mom’s body
3. Contrasted when baby unswaddles

4. Kneeling at her side protects C/S wound as a bedside form of football hold

E. Side-lying position

1. Student “mom” said she did this herself with her baby
2. Pillow wedged at her back or dad spoons her or supports her back with his back facing away from her.
3. Lower leg straight
4. Pillow between legs
5. Towel to support abdomen if C/S
6. Baby’s mouth placed lower than her nipple as he will tilt his head back and reach for the breast which places him assymetrially on the areola
7. Pulls lower body in towards her
8. Pillow at her back
9. Student mom said she felt more back support in laid-back position as uses less muscles than in side lying
10. Big bed needed for safety
11. Student asks about swaddling to keep hands from baby’s mouth
12. Discussed hands always near mouth in the womb
    1. Hands act as a locator (Klaus)
    2. Hands across the eyes shut out too much stimulus
    3. File nails backward and let hands go

4. Baby will move his hands when ready (2nd baby in"Baby Self Attaches" DVD)

13. Does better more prone and not dorsal if baby is on his side

F. Different students practice

1. Elbow support while mom bolt upright
2. Tries cross cradle hold in this position
3. Back support pillow limiting laid-back position
4. Mom complains – can I let go of the breast?
5. Instructor intervenes for more laid-back
6. Student mom wants to place baby oblique naturally – she feels it intuitively
7. Students caution on head manipulations

G. Students change roles

1. Suggest pillow under her knees – warned about post C/S blood clots
2. Demonstrated how to support legs with pillow at the sides
3. Shifted baby from dorsal to prone
4. Demonstrated how to do twins in bed
5. Student mom felt she wanted to see the baby so adjusted pillow differently
6. Tries side-lying
7. Practiced turning onto her side with towel there for tummy support
8. Pillow between legs

9. Added baby and moves baby lower than nipple
10. Mom's arm above baby or supporting his head
11. Student mom likes side lying as she can see the baby
12. Demonstrated back to back support
13. Rolls receiving blanket to support baby's back
14. Discussed beds with a rail for protection or a foam bed between the parents and safety issues.
    1. Concluded that it separates mom and baby
    2. Sides too high
    3. Did work as an arm rest for mom
15. Students ask how to you deter mom from swaddling?
    1. Damp clothes means baby is too warm - sweating
    2. Undress the baby
    3. One parent's body heat higher than the other so avoid covers over baby
    4. Skin to skin offers perfect body temperature
    5. No heavy comforter over baby
16. Caution to not have baby prone if mom lays flat – safer for baby's airway if mom on a 45° angle