

## **Winnie Madding Report on Advocacy track at ILCA Post-Conference – 2007**

### **WORKING WITH GENERATION X AND Y WOMEN**

“Who you are is where you were then” Much info from marketing research – “Every individual is shaped by the history he or she lived through during the formative years. These distinct historical experiences create characteristics that stay with people throughout the rest of their lives.”

**Depression era** = thrifty; Vietnam era = suspicious of government; 70's = comfortable with gadgets

**Baby Boomer** characteristics – 1946-1964: Optimism – equality for all; Tenacious – work hard, stick to it; Team players – brainstorming; “Change is a good thing”; Comfortable challenging authority; Self-improvement a goal; Idealistic – “Breastfeeding is every baby’s right”

**Generation X** – 1965-1981: Lean toward cynicism and skepticism – even in their humor; Groups/teamwork not their thing; Want quick results; Their friends are their family; Self reliant (original “latch key kids”); Very comfortable advocating for themselves; Think globally; Read less/travel more; Want balance and fun in their lives; Techno-savvy; “If you don’t like what’s going on, quit”; “Parents made a mess of things”; “Wait” is a 4-letter word; High epidural/low breastfeeding rates

**Generation Y** (nexters) – early “80s to present: More inclined to be team players; Social involvement/commitment; Less cynical and more hopeful than gen Xers; Street smart; Even more techno-savvy – like the internet for information; Quick fixes/tool users

**Working well with the Next Generations:** Quick solutions; Sound bites; Forgo your own stories; Include advantages for mother and father; May not be as interested in mother support groups; Need caution that everything on the internet is not accurate; Proclivity for quick fixes and tools means they welcome the use of things like a nipple shield if it makes it easier for mom or baby. Why struggle when a tool is available?

**SO?:** It is important to realize that moms today may not think like we have learned to think. We have to “meet them where they are”; “Staying current with current the generation’s attitudes is as important as staying current with lactation research.”

### **LEARNING TO LOBBY FOR PRO-BREASTFEEDING LEGISLATION**

What the Texas Coalition has learned: Power belongs to the people; Lobbying-the process by which legislation is influenced by a special interest group-it’s not just bribing by sleazebags!; You learn to lobby by lobbying; Time and focus (NOT MONEY) are the key; You have to be willing to lose since you may well not get what you want the first try and you may also face ridicule; Keep the overall goal in mind; Their goal – Reframe breastfeeding from a lifestyle choice to a public health issue

**Tips:** Know the atmosphere of your legislature – i.e., Texas is very casual while others may be very businesslike (power suits etc.); Identify barriers to breastfeeding that might be addressed by legislation; Be respectful; Keep

your sense of humor; Keep your requests reasonable and support them with careful documentation; DO NOT APPEAR FANATICAL – that’s how our opponents will try to paint us; Prepare ahead-have a timeline; Develop a one-page White Paper – KISS; Identify supporters and stakeholders (those with an interest on either side); Someone up for reelection in a highly contested district may not be the best choice-may not be around when the bill comes up; Know the legislator’s aides – they can make or break a bill What they have proposed and accomplished: **Breastfeeding Rights Bill** – 1995; Moms can nurse anywhere they have a right to be; Provisions for employers to become identified as a Mother Friendly Workplace – now 80 companies; 2001 – **minimal guidelines for human donor milk banks**; Texas now has 2 banks; Medicaid funding for donor milk

**What they haven’t accomplished:** 3 tries for licensure; Insurance lobby shot it down; Killed on constitutionality (?); Designation of Breastfeeding-Friendly Physicians – died due to calendar issues; Bill to ban “gift bags” in hospitals and clinics – they didn’t expect it to pass, but it did act as an annoyance factor to formula companies; Title protection for term “Lactation Consultant” – 2007 – killed in committee by critical opposition; Strengthening of BF rights bill (earlier one had no “teeth”) – linked in commit hearings to above bill – will keep trying Community Action Kit for Protecting, Promoting and Supporting Breastfeeding, Texas Department of State Health Services, WIC <http://www.dshs.state.tx.us/wichd/bf/bfl.shtm>

## **ILCA Report by Anne Altshuler, September 21, 2007**

### **Challenges and Risks of Mothers with Eating Disorders Dr. Patricia Mcveagh, Australia**

There is a high incidence of eating disorders. 9 out of 10 are female. Few are diagnosed or treated, and only 2% receive mental health services, even though this is a potentially lethal condition. Along with substance abuse, this is the most lethal psychiatric disorder.

**Anorexia nervosa** Age of onset: 10 – 15 years old – about 25% 16 – 20 years old – about 43%

This is a chronic disease. 30 – 70% recover, 30% have a poor outcome, 30% die. The younger the age at diagnosis, the better the outcome. Girls who are dieting, have low self-esteem, and poor body image are at risk for eating disorders. Denial is a part of the illness. May act unconcerned, confused, defensive, eager to rationalize, hostile, defiant. Secrecy and deception are common. Most are “good girls.” Parents are also often in denial. Say the girl couldn’t be vomiting. But the potassium levels in their blood show that they ARE vomiting. Common to see lack of behavioral change in a very compliant patient. They say they will cooperate, but they don’t. Anorexia Nervosa is the most common in the younger age group. These girls refuse to maintain a body weight at or above the minimum normal for their height and age. They have an intense fear of gaining weight. They either refuse to eat or else purge or over-exercise. Pretend

to eat, push food around on their plate, cut it into tiny pieces, tell friends they ate at home, tell parents they ate with their friends. Claim to be allergic to many foods, to be vegetarian. They do feel hunger. Compensate by drinking water. Constantly jiggling, moving, exercising primarily to lose weight. Preoccupied with weight. Check the mirror frequently. Wear baggy clothes to hide their thinness. A very competitive illness. Use cell phones, internet, to compare who lost the most weight, share weight loss tips. In hospital – each wants to be the thinnest, the “Queen Bee.” Physical effects: Low body temp. Starving brain leads to structural abnormalities, gray matter is lost, with cognitive impairment. Delayed bone age, height suffers. Don’t lay down a good bone mass, may develop osteoporosis in pregnancy. Amenorrhea

### **Bulimia:**

Affects a slightly higher age group. Around 15 is the mean age. Recurrent periods of binge eating with vomiting to compensate. Harder to pick out. May have a normal BMI. Electrolyte imbalances. Look for a callus on the knuckle or the palate, where they induce vomiting. Teeth and mouth affected by the vomiting. Often also engage in self-harming behavior like cutting or burning. Very little scientific data on eating disorders. We don’t know, for example, whether having been breastfed or formula fed as infant has any relationship to later eating disorder.

**Issues of eating disorders with childbirth/breastfeeding:** Pregnancy and the post pregnancy period is a time of challenge for those with eating disorders. Some have remission of symptoms until delivery.

For some women, the desire to lose weight postpartum triggers an eating disorder. With bulimia, symptoms mostly improve during pregnancy. 50% relapse after delivery.

**Breastfeeding:** Women with eating disorders are more likely to breastfeed. (May see it as a way to lose weight). Their babies are more likely to experience difficulties with slow growth, acting hungry after feedings. More likely to wean early. More likely to have postpartum depression. Cognitive features characteristic of anorexia nervosa affect breastfeeding: perfectionism, need for exercise, personal issues around eating may lead mother to restrict food given to growing infant, may dilute bottles, have less food in the home.

### **How to deal with the situation:**

Early identification and treatment is important. Need team approach to avoid being caught up in the "splitting" mechanism. Agree on a treatment plan. Ally with colleagues Try to engage the mother. Gain her trust. Only then, ask “Has anyone ever been concerned that you have an eating disorder?” or “Do you have an eating disorder?” Then introduce idea of getting help. Don’t be confronting. Don’t back them into a corner.

## **ILCA 2007 Report Marcia Barritt**

### **Safe and Breastfeeding Compatible Oral Behaviors for the Infant Receiving a Bottle: Lisa M. Sandora MA, CCC-SLP and Karen Gromada MSN, RN, IBCLC**

Reflexes at birth assist with feeding and are gradually integrated into voluntary movement. Newborn sucks reflexively and needs to be taken away from the breast in order to latch. Infant has protective and adaptive reflexes. Sucking is reflexive during the first 0-3 months and the tongue and jaw move together in an up and down pattern. After 3 months sucking is no longer reflexive. Prenatally, the tongue begins to move by 18 weeks and is not linked with swallowing until after 34 weeks. Swallowing rhythm stability begins to be established between 34 and 40 weeks. Prenatally, the fetus is swallowing large amounts of amniotic fluid. After birth, the infant brings the sides of the tongue up to keep the bolus in the middle of the tongue. The bolus is the trigger to swallow and the infant stops breathing during swallowing so that nasal reflux doesn't occur. The tongue and epiglottis move up and backward as peristalsis moves the bolus through the esophagus involuntarily. The maturation of respiration occurs between 32-40 weeks, prior to this time the infant has more difficulty coordinating suck, swallow and breathe. Colostrum is thick and is low volume so that the infant utilizes fewer sucking bursts and swallows. Infant temperature, respiration rate, heart rate and oxygen saturation are better in the breastfed infant. Breastfeeding is airway protective and the infant has more control of suck swallow and breathe. The higher bolus associated with bottle feeding causes stress cues, airway distress, clenching and biting. Drooling occurs when there is lowering of the cheek tone to get rid of some of the bolus.

## **ILCA 2007 – Becky Krumwiede**

### **Preterm Expression and Storage of Colostrum: A Positive Step for Mothers and Neonates**

#### **Sue Cox**

Breast preparation and expression of colostrum during pregnancy used to be quite common; was thought to open up the ducts. Studies during the 80's and 90's investigated the effect of oxytocin release during nipple stimulation on cervical changes and induction or augmentation of labor. Studies had varying but long periods of nipple stimulation (30 to 110 minutes) and showed an increase in cervical ripening *if at term*, but no significant effects on inducing labor, the length of labor, or fetal outcome. Since oxytocin is released by other activity, if it's okay for women to kiss, masturbate, and have intercourse, it's okay for them to express colostrum. Women she suggests might want to express colostrum prenatally would be those with conditions that might lead to early supplementation. Women with breast hypoplasia, polycystic ovarian syndrome (PCOS), previous breast surgery, inflammatory bowel disease, Type I and gestational diabetes.

Suggestions for prenatal expression of colostrum:

discuss with health professional

start at 34 weeks after appt. with IBCLC to learn expressing technique and obtain 1 and 3 ml syringes

express for a few minutes on each breast after showering when breasts are warm

stop expressing if feel cramping pains – discuss with health professional at next visit

draw up drops of colostrum with 1 or 3 ml syringe

use same syringe for 48 hours then store in a zip lock bag in freezer

if good flow, express into small, clean med cup or spoon and draw colostrum up with the syringe

advise Dr. / midwife / IBCLC that frozen colostrum will be brought to the hospital

write birth plan that includes uninterrupted skin to skin contact and colostrum available in the freezer

**Advantages:** “Supplementing the baby in the early days with colostrum which has been expressed and stored during the pregnancy may assist in keeping the baby hydrated and feeding actively. Active feeding then provides maximum stimulation to increased prolactin receptors in the breast resulting in higher milk production so that less supplementation may be necessary.”

**Conclusion:** “As expressing and storing colostrum is advantageous to infants and confidence building for women, it should be suggested not only for the conditions described in this paper but also for any other conditions which the health professional considers necessary.” Sue said that they have been following this protocol for 10 years now.

### **Using Diaper Counts to Assess Breastfeeding Adequacy—Are wet and soiled diapers a valid indicator? Laurie Nommsen-Rivers**

The ‘gold standard’ marker of BF adequacy is adequate weight gain. “Counting diapers” is based on the theory of output proportional to intake. Statistics given came from the UC Davis Risk Factors Study (prospective; 280 mother-infant pairs; full term, healthy newborns; mothers given lactation guidance in hospital and on day 3, 7, 14 and as necessary—as ideal as it comes in this country). Mothers kept records; babies were weighed on day 4 visit (72-96 hrs. postpartum).

**Summary:** Evidence supports a significant *relationship* between diaper output and breastfeeding adequacy. There is some clinical usefulness in monitoring output but available evidence suggests this relationship is not strong enough to allow soiled diaper counts alone to be used as a screening tool. The most promising markers to screen for breastfeeding inadequacy on day 4 are the combination of less than 4 soiled diapers + onset of breast fullness at later than 72 hours postpartum. Taken together, those markers correctly identified 86% of babies with excessive weight loss, but only correctly identified 59% of the babies of normal weight loss.

**Conclusions:** All breastfeeding newborn infants should be seen by a pediatrician or other knowledgeable and experienced health care professional at 3-5 days of age as recommended by the AAP. Telephone screening is inadequate. Setting the cut-off high enough to catch all those with breastfeeding inadequacy results in so many false positives that screening is no longer useful.

### **ILCA Report 2007 Jenny McAllister**

#### **IBCLC and Speech Language Pathologist: Looking beyond latch and positioning to overcome Suck Difficulties.**

Amy Peterson, BS, IBCLC Private Practice, Jerome, ID. **“WHEN BREASTFEEDING SUCKS”**

“Refer for suck training” is ambiguous. Why? When? To Whom?

**Pros and Cons** of oral Assessment: May be possible to fix without an oral assessment  
Somewhat invasive Introduces foreign item to infant mouth

**Pro** – Helps recognize the range of normal in order to I.D problems Isolating a specific problem may speed correction  
**Flags for Oral Assessment:** baby won't latch after repeated attempts LC will not return before discharge and successful latch has not been observed Mother states it doesn't feel right or it hurts throughout feeding. OR after discharge and still having problems

**Speech Language Pathologist (SLP)**- Address infant muscle and motor problems related to suck and swallow. OT – Focus is on fine-motor skills and sensory integration  
Pedi Chiropractor – adjusts neck and spine to improve comfort and nerve flow. Cranio-Sacral Therapist – Gentle touch to offset the forces birth puts on a baby's skull and neck. Physical Therapist – Focus on gross motor skills  
Neuro-Developmental Therapist – Whole body approach

**NOTE** Different philosophies among SLP /OT practitioners. Train to breast VS Fix to bottle

Train to breast requires more patience, dealing with the unknown, More visits required.

VS with fix to bottle approach – Easier to assess, Intake is the goal rather than oral strengthening needed to breastfeed, and fewer visits needed.

### **Recognize Our viewpoints differ**

IBCLCs try not to intervene, work within range of normal, tweak things a little so breastfeeding can resume. SLP/OT often work within the range of abnormal and syndromes, look for an undiagnosed problem, and are more comfortable intervening. Stay within our scope. Let them stay within theirs. Our job isn't to "fix the sucking" problem, but to protect and transition back to breast. When possible be present with mom and baby when they meet with SLP/OT

**THE BIG 4** Tongue lips cheeks jaw. Oral anatomy works in conjunction with each other. When one part isn't working, baby will compensate with a different part in order to feed. Isolate the weak area, see if it's within our scope to correct over a couple of days, refer if it doesn't improve.

**WARNING** There are risks when lactation counselors without special training recommend techniques without also having the education or the background to understand the overall impact they may have on a baby.

**Tongue Retracted** – Try practice licking: prone position, gentle tapping on lips gentle rocking, nipple shield, temporary longer bottle nipple using mild downward pressure.

**Tongue Disorganized** – Assess: sliding side to side – floppy. Try tongue stroking; intro milk with finger feeding.

### **Tongue breaking suction**

Assess: up-down motion rather than AP sliding. Sometimes babies use this motion for incorrect bottle feeding. (nipple too fast). Try Chin tucked, Support tongue under jaw. Non nutritive suck (finger, Soothie bottle) rhythmically sliding to engage tongue 1/sec, slight pressure downward; add milk with same technique.

**Lips** Flange, Seal , Blisters, - Roll out if needed. Is baby gaining and mother comfortable anyway? Lip Tone : Seal - Assess seal on breast, finger, spill with bottle? Corners loose, thin, stretchy. Pop when finger removed?

**Cheek strength** – nursing blisters, lips may be compensating, or tongue compensating?

Try Dancer hand position. – stabilizes weak muscles with gentle pressure.

**Jaw Movement** inappropriate?

Try – Breast compression, SNS, Elicit nutritive suck, with bottle using slight pressure downward, rhythmically pulling forward and back to engage tongue 1/sec.

**Munching** – a combination. Tongue retracted, gums bite, weak tongue, Lack of coordination with SSB.

Try – techniques for “ retracted tongue and tongue breaking suction.