Supporting Families, Building Confidence, and Increasing Breastfeeding Success

Clinician Corner

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Helping families feel more confident can lead to greater breastfeeding success. IBCLCs can play a role in this. They can help families learn to trust their own parenting abilities, trust themselves, and trust their babies to tell them what they need. This article outlines many practical tips for IBCLCs to try. Better communication leads to improved relationships with families and this in turn can help families learn to trust themselves.

Keywords: breastfeeding; self-efficacy; maternal confidence; breastfeeding support; motivational interviewing

Being conscious of the IBCLC's body language is important when working with families (Benbenishty & Hannink, 2015). If an IBCLC comes into a breastfeeding consultation flustered, shuffling papers, and in a rush, the anxiety of the family will rise. Even if your mind is racing, consider trying to portray a calm outer appearance. When sitting down with the family, take a deep, relaxing breath. Model deep, slow breathing. This can help calm everyone down. Breathing and mindfulness are being used to help reduce pain (Hilton et al., 2017) and can increase confidence. Really take a moment to be present with the family and just breathe (Braun, Kinser, & Rybarczyk, 2018)!

As you are breathing, try to make eye contact with everyone. Gently smile. Ask in a relaxed, calm tone, "How can I help you today?" or "Tell me about what brought you here today?" Lean forward to show you are listening. Simply listening carefully to a family's story can be very healing (Berman & Chutka, 2016). By being attentive to the family's story, you are showing respect and acknowledging that the family is the expert on their baby.

Before the consultation begins, let the family know how the visit will proceed and the timing of the consultation (Figure 1). For example, "The baby seems hungry [at this point taking a minute to explain hunger cues is very useful], so if it's okay, I would like to do a weight before the baby feeds, breastfeed, and then weigh the baby after, so we can see what is going on and get some information to help us make decisions later. Then we can go over your health history and any concerns about your breasts and nipples to make sure everything is okay, and I'll check the baby to see if we can figure out why he could be having trouble getting milk, watch you pump so we make sure it is going well, show you a method of supplementing that many families find to be helpful, and then we can create a plan together. Any time you have questions, please ask them, but I will make sure there is time at the end for more questions. I also want to make sure that we have a follow-up plan in place. We should be done around 11 a.m. Does that sound okay?" No one really likes surprises, so letting families know the plan for the consultation and for how the appointment will proceed can ease tension.

Figure 1. Explain how the visit will proceed.

Motivational interviewing (MI; Miller & Rollnick, 2013; Rollnick, Miller, & Butler, 2008) is a powerful technique for working through challenging situations. Here is a very brief description of some of the central elements. The first and key element is the spirit of MI: a Venn

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diagram of overlapping circles of compassion, empathy, respect, acceptance, and collaboration. These attributes are used to help form a full understanding of this family's situation and then to help them find solutions they feel might move them toward their goals. The key strategies are known by the acronym OARS: Open-ended questions, Affirmations, Reflections, and Summaries. These harken back to La Leche League's communication skills!

As the family is telling their story, take time to ask open-ended questions (O in OARS) that help them give more details. "Tell me more about that," is a favorite line. For affirmations (A in OARS), listen for areas where the family is really doing well and tell them that (Figure 2). Giving sincere, positive feedback to the family during a consultation will help to build confidence for a family that is feeling unsure. Make sure they are true compliments. Don't tell the family they have a beautiful baby unless it is true! Reflections (R in OARS) are a way to reinforce what the family is telling and showing that there is a real understanding of what the family is saying. And finally, a summary (S in OARS) is an opportunity to let the family know you have listened closely.

> *Let me see if I understand. You thought everything was going well, but when you went for a weight check the baby's weight was down. The doctor told you that you weren't feeding the baby enough, and to give 2 oz of formula after every feed, and you have been doing this for 5 days now.*

Make sure the emotions are in there as well. "When the doctor told you he didn't think the baby was eating enough, it made you feel scared because you thought everything was going well." Reflections and summaries are statements, not questions. If you have gotten a detail wrong, the family will correct you. An easy-to-remember, simplified version of MI is LOVE: L—Listen, O—Open-ended questions, V—Validate, E—Educate (Hetzel Campbell, Lauwers, Mannel, & Spencer, 2019).

During the consultation it is important to try not to show judgment (Koh, 1999). This can be very difficult when families have been given misinformation in the past. Shaming a family by behaving as if what they are doing is crazy or counterproductive will quickly erode the relationship with the family and build barriers. For example, a little baby comes in that is clearly (to you!) being underfed and have the family reports their baby is "fussy," "spoiled," or "greedy." The poor baby is most likely just hungry! But starting to give advice as to how to fix things without helping the family see what you are seeing reduces the likelihood of change. However, by gently

Figure 2. Watch and listen carefully.

sharing your observations as the consultation progresses (pre- and postweights are great for this), families come to their own conclusions and will often say toward the end of the visit, "I think the baby is just hungry!" "Everyone has been telling me he is just demanding but it seems like he just isn't getting enough food!" Exactly! Once the family has the same understanding we do of the problem, it's easy to work with them to find a solution.

Asking permission and explaining why touching is needed to best help, before touching the mother or the baby, are always essential (O'Lynn & Krautscheid, 2011) (Figure 3). Many families feel like they have been treated roughly, physically or emotionally, by healthcare providers in the past. Asking permission clearly demonstrates the understanding that this is their body, their baby, and their choice. This preserves the client's autonomy and control, and shows respect.

Consider avoiding using lactation jargon if possible (Hayes, Dua, Yeung, & Fan, 2017; Rimmer, 2014). Jargon can make a family feel out of their comfort zone. If a mother comes in and is talking about her "boobs" hurting, telling her, "No wonder! I see a possible infected Montgomery gland on the right, upper left quadrant of your areola" may make the situation more medical than it needs to be. Using analogies, such as, "Babies see with their hands" (an aspiring IBCLC) instead of, "Don't swaddle the baby while you are feeding." Or "Think of a nipple shield like training wheels for a bike. The training wheels make it so you don't have to worry about falling over so you can focus on starting, stopping, and steering. The nipple shield can help the baby be able to focus on

sucking, swallowing, and breathing, not keeping the nipple is their mouth" (Barbara Robertson). These analogies can help families see the rationale behind suggestions.

One of the most important ways to help families is to give them accurate biomedical information. Sharing with them appropriate weight gains, milk volumes for the baby to consume, and signs of a well-fed baby helps them feel more in control. Often during the early weeks, the healthcare providers seem very worried about weight gain but then, suddenly (as it appears to families), become unconcerned. It is not clear to families what happened. What were they doing that was not working, and what did they do that did work? Demystifying the whole experience is important. A common technique to help babies gain weight is often the direction from healthcare providers in the Ann Arbor, Michigan, area is to "Give 2 oz of formula after every breastfeed." What is the baby is eating 10 times: 20 oz? Two times: only 4 oz? Also, what if the mother has breast milk she could express from her breasts? Could she use this instead? During a consultation, all the information to provide guidance on how much and how often a baby needs to eat is being gathered.

At the end of a breastfeeding consultation, families should leave with a clear, agreed-upon plan that ensures the baby is well fed and they are moving toward their breastfeeding goals (Figure 4). Again, there is the need to address their fears and reluctance as they come up. One mother did not want to supplement her 2-week-old baby because she was afraid he would become overweight and struggle with obesity later in life, as this mother had. This information was uncovered using MI techniques.

Figure 3. Always ask permission and explain what you are doing and why.

If families seem resistant to a suggestion, ask them to tell you more about their thinking. "It seems like we are on the same page about how much the baby should eat and how often you should express your breast milk. I feel there is some reluctance about paced bottle-feeding. I am sure you have good reasons! Tell me more about what is going on so I can understand." Usually the families will share their thoughts, and they do have good reasons! Often resistance is due to the family having outdated information or misinformation concerning breastfeeding. Another example of this is washing nipples with soap and water if there is nipple damage. Families have read on the Internet and/or in books, "Never use soap on your nipples." You might say, "Many families have read to not use soap on your nipples, but if you think about a cut on your arm, wouldn't you keep it clean while it's healing?" Once the rationale has been explained and

Figure 4. Help the family create a plan for their baby.

Figure 5. Don't forget breastfeeding support groups!

the misinformation identified, the family may then feel comfortable with the suggestion.

During the consultation and especially at the end of the visit, let the family know the care plan contains the best strategies based upon the information gathered during the time spent together. Again, harkening back to La Leche League, "Take what works for your family and leave the rest behind." Not all the options considered during the consultation are going to work for every family. Let families know there are more ideas to try if the initial plan doesn't work or is too difficult. This both leaves the door open if the care plan is difficult to implement, and shows humility about our inability to predict every outcome. Encourage families to do more of what is working well, and less of what is not. Establish a way to touch base in a few days so families understand you will work together to modify the plan as needed.

It's particularly important to make provisions for reweighing the baby within 3 days of the consult to confirm the infant is gaining and rebuild the family's confidence. The weight check can occur at the healthcare professional's office, a follow-up home visit, or the lactation consultant's office. Offering a free drop-in support group is a great way for them to check on the baby's weight (Figure 5).

MI techniques are particularly helpful in building a family's confidence after initial poor infant weight gain. It takes conscious effort to gain trust and empower families with accurate information. Not all these suggestions are for everyone. However, by using a variety of the preceding suggestions each healthcare provider can help families increase their odds of reaching their breastfeeding goals.

References

Benbenishty, J. S., & Hannink, J. R. (2015). Non-verbal communication to restore patient-provider trust. *Intensive Care Medicine, 41*(7), 1359–1360. doi:10.1007/s00134-015-3710-8. Retrieved from https://link.springer.com/article/10.1007/s00134-015-3710-8

Berman, A. C., & Chutka, D. S. (2016). Assessing effective physician-patient communication skills: "Are you listening to me, doc?". *Korean Journal of Medical Education, 28*(2), 243–240. doi:10.3946/kjme.2016.21. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4951737/

Braun, S.E., Kinser, P.A., & Rybarczyk, B. (2018). Can mindfulness in health care professionals improve patient care? An integrative review and proposed model. *Translational Behavioral Medicine*. doi:10.1093/tbm/iby059. Retrieved https://www.ncbi.nlm.nih.gov/pubmed/29945218

Hayes, E., Dua, R., Yeung, E., & Fan, K. (2017). Patient understanding of common oral medical terminology. *BDJ, 223*, 842–845. doi:10.1038/sj.bdj.2017.991. Retrieved from https://www.nature.com/articles/sj.bdj.2017.991

Hetzel Campbell, S., Lauwers, J., Mannel, R., & Spencer, B. (2019). *Core curriculum for interdisciplinary lactation care.* Burlington, MA: Jones & Bartlett Learning.

Hilton, L., Hempel, S., Ewing, B. A., Apaydin, E., Xenakis, L., Newberry, S.,. . . Maglione, M. A. (2017). Mindfulness meditation for chronic pain: Systematic review and meta-analysis. *Annals of Behavioral Medicine, 51*(2), 199–213. doi:10.1007/s12160-016-9844-2

Koh, A. (1999). Non-judgmental care as a professional obligation. *Nursing Standards, 13*(37), 38–41. doi:10.7748/ns1999.06.13.37.38.c2612

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Preparing people for change.* New York, NY: Guilford Press.

O'Lynn, C., & Krautscheid, L. (2011). "How should I touch you?": A qualitative study of attitudes on intimate touch in nursing care. *American Journal of Nursing, 111*(3), 24–31. doi:10.1097/01.NAJ.0000395237.83851.79. Retrieved from https://nursing.ceconnection.com/ovidfiles/00000446-201103000-00025.pdf

Rimmer, A. (2014). Doctors must avoid jargon when talking to patients, Royal College says. *British Medical Journal, 348*, g4131. doi:10.1136/bmj.g4131. Retrieved from https://www.bmj.com/content/348/bmj.g4131

Rollnick, S., Miller, W. R., & Butler, C. C. (2008). *Motivational Interviewing in health care: Helping patients change behavior.* New York, NY: Guilford Press.

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Infant and Early Childhood Mental Health Resource Compilation, From ZERO TO THREE

ZERO TO THREE has worked with the National Child Traumatic Stress Network and the Alliance for the Advancement of Infant Mental Health to launch a webpage featuring resources (available in both English and Spanish) for parents, caregivers, and professionals working with very young children who have been impacted by separation and other trauma. The webpage includes a directory of state infant and early childhood mental health (IECMH) contacts who have volunteered to field inquiries and make connections to resources and clinicians: https://www.zerotothree.org/resources/2384-supporting-young-children-experiencing-separation-and-trauma

Source: USBC