NAVIGATING ADVICE

Pediatricians on Infant Feeding & Sleep

What do we know and more importantly what do *they* know?

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PEDIATRICIAN KNOWLEDGE OF INFANT FEEDING, PRIMARILY LACTATION:

- A survey of pediatric program directors in 2006 to 2007 concluded that pediatric residents received an average of only 3 hours of breastfeeding training per year.

- Concerning trends from the 2014 Periodic Survey of Fellows were that pediatricians were less likely to believe that the benefits of breastfeeding outweigh the difficulties or inconveniences encountered and that younger pediatricians felt less confident in their ability to manage breastfeeding despite being more predominantly women and having more personal breastfeeding experience.

Meek JY. Pediatrician Competency in Breastfeeding Support Has Room for Improvement. Pediatrics. 2017;140(4):e20172509

It's important to note that in 2020 not much has changed in the amount of education and lactation knowledge that med students and practicing pediatricians receive. While things *are* slowly improving as more pediatricians seek out training and knowledge on their own (there are even some unicorn pediatricians who actually certify as IBCLCs), by and large, pediatricians still receive very little training in breastfeeding/infant feeding and this is problematic. They are often the first healthcare providers making contact with new parents post birth during the critical early days/weeks of feeding initiation.

Does this make them "bad" or "incompetent" doctors? NO.

But it is important to note that in this particular area they may not be the *BEST* source of information and support.

But who is? And more importantly, how do we advocate for ourselves and collaborate with our child's doctor to help keep our children healthy while achieving our feeding goals?

What does the bad advice even look like?...

WHO SHOULD BE PART OF YOUR CARE TEAM TO COLLABORATE WITH YOUR PEDIATRICIAN?

It's important to know and advocate for a collaborative approach with your pediatrician and other important care providers. Apart from recognizing bad pediatric advice it's also important to know who to turn to for comprehensive assessment and evidenced based lactation support. Especially if your child's healthcare provider is concerned feeding is not going well or concerned with your baby's weight and growth. Here's a brief list of care providers you can seek referrals for and consult with when issues arise.

All issues related to your breasts/chest, painful latching and feeds, damage/trauma to your nipples, breast pain/infection, suspected low supply, baby weight loss, difficulty latching and staying latched:

- International Board Certified Lactation Consultant (IBCLC) or Certified Lactation Counselor (CLC)
- Your primary care provider
- A Breast Specialist
- Pediatric Dentist [possible tie assessment]
- Speech & Language Pathologist [oral therapies]
- Pediatric Occupational Therapist (OT) or Myofunctional therapist [body work and oral therapies]

All issues related to GI issues such as allergies, reflux (GERD), decreased stooling to less than 3xs per day in the first 6 weeks and less than 3x per week after 6 weeks:

- International Board Certified Lactation
- Consultant (IBCLC) or Certified Lactation Counselor (CLC)
- Pediatric GI
- Body work specialists- Ots, Chiropractors, Craniosacral therapists

WHO ELSE CAN BE PART OF YOUR CARE TEAM OR WHAT HELPFUL RESOURCES EXIST?

All of the care providers in the previous list should be working collaboratively with your child's doctor and providing him/her with documentation of their assessments (with your consent) and vise versa. This team approach increases the likelihood of achieving your feeding goals while working with and not against your child's pediatrician.

Extra community support is also helpful and can be found via:

- Peer breastfeeding support via your local WIC office (if you qualify)
- Local La Leche League groups/meetups/leaders
- Local postpartum support groups via local birth centers or your local hospital
- Virtual mom support groups

Important resources of information:

- Infant Risk Hotline 1-806-352-2519
- The LactMed app to check how any medications you are prescribed impact breastfeeding and alternatives if the medication is not compatible with breastfeeding.

"ADVICE" | EVIDENCED BASED INFORMATION | IDEAS ON HOW TO REPLY

• "You should only feed for __min on each breast" This is false. You should never limit/restrict feeds at the breast. Research indicates the importance of responsive, cue led, feeding for all babies, including bottle fed infants. "Do you have a referral for a lactation consultant I can speak to about this?" "I'm confident in reading my son's hunger and satiety cues now, but thank you." "I'll speak to my lactation consultant about this and perhaps you can both collaborate on this matter."

• "Your milk is just water after __months." False. Human milk has been shown to shift and change in it's composition within the same 24 hrs between feeds and from day to day depending on the needs of the child and duration of lactation and it is NEVER just water. In fact, we are still researching and discovering the many beneficial components that make up human milk. "That doesn't seem to be aligned with the information provided by the WHO and the research on breast milk composition I've read." "I'm confident my milk is providing my child the water and also important nutrients that they need." "The WHO and AAP recommend breastfeeding for at least the first 12 months of life and preferably the first 2 years of life." "That's interesting, I'll discuss this with my LC."

• "You should start solids at 4 months because your milk is not enough." False. It is now recommended and perfectly safe to begin solids at 6 months. An infant adequately fed with human milk (or formula) does not need to start on solids until the 6 month mark. Human milk is more than enough and should remain the primary nutrient source for the first 12 months of life. "I trust my body and the milk it produces for my baby." "This information does not align with WHO recommendations. I will have to look into this further." "I will speak to my LC about this."

"ADVICE" | EVIDENCED BASED INFORMATION | IDEAS ON HOW TO REPLY

• "Your baby is having reflux because they're over feeding at the breast. You should limit feeds and spread them out to every 3-4hrs." Reflux can be a normal and harmless occurrence in infancy or in the case of GERD it can be painful for the infant and its cause would need to be addressed. In either event, it is not caused by overfeeding at the breast and it does not warrant decreasing feeds at the breast. It *does* warrant further investigation into what may be causing the reflux like aerophagia(often related to ties) or other GI specific issues like allergies that can impact GI functioning. "Before considering reducing my child's only source of nutrition, I'd like to speak to a GI specialist about this." "I would love to collaborate with a GI specialist and lactation consultant on this issue. Can you refer me to any?" "I'll communicate this to my LC and perhaps you both can collaborate together on this issue and offer me other options." "I'd like to explore all other options and causes before I limit my child's feeds."

• "You need to wean at __months" or "Babies don't need any night feeds by __months." First, weaning is a parent's decision. The WHO recommends exclusive breastfeeding for the first 6 months and continued breastfeeding along with complimentary foods till at least 24 months or beyond. Further, there is no research that indicates a specific age at which time infants are officially ready to fast for prolonged periods, as this is influenced by factors such as how well feeding is progressing, weight gain, and total calories consumed during the day. Research does find that weaning from any day/night feeds before the 4 month mark is not advised. Night weaning also has no impact on how long and how well an infant will sleep at night. Studies have found that infants who were weaned at night by 6 months still woke in the night up to the 12 month mark and beyond. Infants will naturally reduce feeds overnight as they grow and when they are ready to do so. When hourly feeds continue on for months, it is recommended that the root cause be explored before fully night weaning before 6-12 months. Ultimately, the choice to night wean is the parent's and not the child's pediatrician based on an arbitrary time frame. "I'm not ready to night wean at this time." "I'm confident in following my child's cues for now."

PEDIATRICIAN KNOWLEDGE ON INFANT SLEEP:

• Overall, the average amount of time spent on sleep education is 4.4 hours (median = 2.0 hours), with 23% responding that their pediatric residency program provides no sleep education. Almost all programs (94.8%) offer less than 10 hours of instruction. The predominant topics covered include sleep-related development, as well as normal sleep, sleep-related breathing disorders, parasomnias, and behavioral insomnia of childhood.

Mindell JA, Bartle A, Ahn Y, et al. Sleep education in pediatric residency programs: a cross-cultural look. BMC Res Notes. 2013;6:130. Published 2013 Apr 3. doi:10.1186/1756-0500-6-130

Pediatricians offer parents lots of advice on sleep, often unsolicited. Yet, they have very little clinical training in biologically normal infant sleep or sleep science. More alarming is that they predominantly offer sleep training and cry-it-out (CIO) as a safe solution to sleep "problems" and even perinatal mood disorders.

"[...]There is a startling lack of empirical research on or psychoanalytic thinking about how sleep-training techniques impact an infant's psychological development. A review of the authorship of parenting literature reflects this substantial omission. Ramos & Youngeclark (2006) found that 43% of parenting book authors lacked professional credentials, 40% were from medical backgrounds, and only 15% were trained in clinical psychology or counseling. This is especially concerning since 96% a sample of 700 pediatricians nationwide "believed it was their job to counsel patients/guardians regarding sleep hygiene, yet few pediatricians (18%) had ever received formal training on sleep disorders" (Faruqui, Khubchandani, Price, Bolyard, & Reddy, 2011, p. 539)."-- Zandoná, Casey L., "Responding to infant sleep-related crying : a theoretical exploration of caregiver response from attachment and object relations perspectives" (2014). Masters Thesis, Smith College, Northampton, MA. https://scholarworks.smith.edu/theses/840

Regardless of whether you ultimately choose to sleep-train, it is important to note that pediatricians are often not the *BEST* source for sleep advice and too often adhere to outdated ideologies/information on infant sleep and parenting.

I have heard from countless parents who have reported that their pediatricians made them fearful of *not* sleep-training, of picking their infant up "too much", or blaming their child's very *NORMAL* sleep/wake patterns on their inability to "teach sleep" or on their breastfeeding relationship.

Total BS.

So, who can we turn to? What solid resources on infant sleep are out there and what does the bad advice even look like?

WHO SHOULD BE PART OF YOUR CARE TEAM TO COLLABORATE WITH YOUR PEDIATRICIAN?

It's important to know and advocate for a collaborative approach with your pediatrician and other important care providers. Apart from recognizing bad pediatric advice it's also important to know who to turn to for comprehensive assessment and evidenced based sleep support. Here's a brief list of care providers you can seek referrals for and consult with when issues arise.

Disordered breathing is often missed in infants and young children but significantly impacts sleep:

- Pediatric Dentist [possible tie assessment linked to disordered breathing]
- ENT(ear,nose,throat doc to rule out obstructions)
- Pediatric sleep specialist (sleep studies to rule out apneas)

Feeding issues can impact a infant/child's sleep:

- International Board Certified Lactation Consultant (IBCLC) or Certified Lactation Counselor (CLC)
- Your primary care provider
- Pediatric Dentist [possible tie assessment]
- Speech & Language Pathologist [oral therapies]
- Pediatric Occupational Therapist (OT) or Myofunctional therapist [body work and oral therapies]

GI issues (sometimes linked to a feeding issue) make babies and children uncomfortable and therefore impact sleep:

- International Board Certified Lactation Consultant (IBCLC) or Certified Lactation Counselor (CLC)
- Pediatric GI
- Body work specialists- Ots, Chiropractors, Craniosacral therapists

WHO ELSE CAN BE PART OF YOUR CARE TEAM OR WHAT HELPFUL RESOURCES EXIST?

All of the care providers in the previous list should be working collaboratively with your child's doctor and providing your child's pediatrician with documentation of their assessments (with your consent) and vise versa. This team approach increases the likelihood of achieving better sleep while working with and not against your child's pediatrician.

Extra clinical support:

- Counseling with a Certified Perinatal Mental Health Counselor/Therapist via www.Postpartum.net
- Visit www.Islagrace.ca for a free resource page on perinatal mental health with downloadable screening tools to complete with PCP.

Other Resources:

- Holistic sleep support consultants, like Certified Baby-led Sleep & Well-being Specialists via www.Islagrace.ca, that DO NOT sleep train.
- Local or virtual moms groups like Baby-led Sleep, The Beyond Sleep Training Project, & Biologically Normal Infant Sleep on Facebook.
- Educated speakers on normal infant sleep like Dr. Tracy Cassels from Evolutionary Parenting and Sarah Ockwell Smith.
- Find safe co-sleeping/bed sharing guidelines at Mother-Baby Behavioral Sleep Laboratory https://cosleeping.nd.edu/ & The Lullaby Trust https://www.lullabytrust.org.uk/safer-sleep-advice/co-sleeping/

"ADVICE" | EVIDENCED BASED INFORMATION | IDEAS ON HOW TO REPLY

• "You should sleep train now or baby will never learn to sleep." This is false. You *never* have to sleep train. Sleep is not a skill, but rather a biological function like breathing. Further, 100% of all children will reach the milestone of connecting sleep cycles and falling asleep independently without intervention. Each child will reach this milestone at different ages. If an actual sleep disorder is suspected, a sleep study with a sleep specialist is recommended. It is also likely that when sleep is disturbed for a baby or young child long-term (nightly hourly wakings for longer than 3 consecutive weeks outside of the first few months post birth) that there is something physiological or psychological impacting sleep. Sleep should be viewed as a symptom of something not allowing baby to rest and it should be addressed holistically. Again, sleep training is never a "should" option. "My understanding is that sleep is a biological function and not a skill." "I trust my child will sleep longer stretches and put themselves to sleep in their own time."

• "Your baby is waking because you still nurse to sleep and have created a bad habit. You should stop nursing to sleep and night wean." False. Night weaning has no impact on how long and how well an infant will sleep at night. Studies have found that infants who night weaned by 6 months *still* woke in the night at least once up to the 12 month mark and beyond. Infants will naturally reduce feeds overnight as they grow and when they are ready to do so. "Nursing to sleep still works for us and I trust my gut on this." "I will bring this up to my LC." "This doesn't align with my feeding goals."

• "Your child should be sleeping 12 hrs at night or their growth and development will be negatively impacted." False. Studies on biologically normal infant/childhood sleep patterns indicate that wakings at night are normal and appropriate, even for young children, and these wakings do not seem to cause poor cognition or development. If wakings become excessive and sleep is disturbed all night, it warrants further investigation of the root cause rather than a focus on sleeping through the night or behavioral sleep interventions. "I trust that my child will eventually sleep longer stretches on their own." "This is a phase of parenthood that I know will pass."

"ADVICE" | EVIDENCED BASED INFORMATION | IDEAS ON HOW TO REPLY

• "The cry-it-out method is safe and effective. You should give it a try." This one is very misleading. Mainly because parents are never informed on how and why extinction behavioral methods "work". They *do* work, but how and why are incredibly important for parents to be informed about. Further, there are actually few reliable studies on CIO and those that are cited as indicating that the method is "safe" are not actually indicating this at all. These studies have indicated that the method is not harmful on certain measures but not that they are safe and beneficial to infants on all measures. This is a very important distinction to make. Further, in some studies the infants who weren't sleep trained exhibited the same sleep patterns as those who were by the 6 month mark and the 3 to 4 year mark, with no noticeable differences between the two. In another study, the infants who were sleep trained still woke as frequently in the night as they did before the intervention in stark contrast to parental report of how well they were sleeping. It was indicated that they simply no longer signaled at wakings (one way in which sleep training "works"). "CIO does not align with my values." "I am ok with my child's normal sleep patterns." "I can make changes without being unresponsive to my baby." "If you suspect there's something abnormal about my baby's sleep, could you refer me to a pediatric sleep specialist?"

• "Sleep training will help your mental health and decrease the likelihood of Perinatal Mood Disorders(PMD)." False. Sleep does not cure PMDs in the same way lack of sleep does not cause PMDs. Sleep deprivation *can* impact mood and cognitive functioning to a degree, but it does not cause PMDs. A caregiver experiencing a PMD can contribute to an increase in wakefulness and stress in their infant, not necessarily the other way around. Further, sleep training can also increase, not lower, anxiety in mothers who are experiencing a PMD. Appropriate screening for PMDs with a primary healthcare provider is essential during pregnancy and postpartum. If a PMD is suspected, appropriate referrals to a mental health care provider is the indicated course of action, not suggesting sleep training. "I would like to work on my mental health without sleep training. Do you have a referral to a mental health clinician?"

FINAL THOUGHTS...

I hope this guide empowers you to feel more confident in your parenting choices and also to consider a collaborative approach with your child's pediatrician.

I *love* my child's pediatrician and I'm sure you love yours as well! It's important to remember that they can still be a really great doc *and* still get it wrong in some areas that they have not received enough training in.

It's my hope that this guide can help you navigate those awkward conversations by being armed with a bit more knowledge, the right questions, and advocating for a collaborative approach with care providers that specialize in lactation and sleep and are more knowledgeable about the many factors that can impact both. As they say, teamwork makes the dream work!

Lastly, this is by no means a definitive guide or the be all end all on this topic. This guide is a jumping off point to empower you with some information and invite you to learn more.

All the best on your feeding and sleep journey!

Gloria

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