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Trifecta Approach to Breastfeeding: Clinical Care in the Integrated Mental Health Model

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Abstract

The breastfeeding experience for the mother and infant is often complicated by a constellation of challenges that are difficult for lactation consultants alone to treat. To address this issue, a breastfeeding consultation clinic at Children's Hospital Colorado developed a multidisciplinary team: a pediatrician specializing in breastfeeding medicine, a lactation consultant, and a clinical psychologist specializing in infant mental health and child development. This Trifecta Breastfeeding Approach meets families' needs by addressing the infant's medical care, functional breastfeeding challenges, and the developing mother–infant relationship, and by screening for concurrent pregnancy-related mood disorders. The Approach also recognizes family dynamics and the transition to parenthood within the breastfeeding consultation. Issues of lost expectations, grief, infertility, high-risk infants, and fussiness often need to be addressed. Case examples here illustrate the benefits of this multidisciplinary, integrated health model. This type of integrated care will likely have an increased presence in health care systems as reimbursement for psychologists' fees and innovative models of care continue to emerge.

Keywords

breastfeeding, infant mental health, integrated mental health, lactation, maternal mental health, pregnancy-related depression

Background

Breastfeeding provides optimal nutrition for infants and an intimate maternal–infant bonding experience that establishes the basis for parenting and interactions.[1,2] Pregnancy-related mood disorders and maternal mental health are inextricably connected to a mother's experience of breastfeeding. Premature breastfeeding cessation has been found to be predictive of an increase in postpartum anxiety and depression.[3]

Because of these issues, the Trifecta Approach—pediatrician, lactation consultant (in our institution, it is a nurse-IBCLC), and psychologist—was developed as an innovative approach that addresses the unique challenges for breastfeeding mothers and their infants (see Note 1).

Development of the Trifecta for the Breastfeeding Infant

Initially, the Breastfeeding Management Clinic (BMC), a consultative breastfeeding clinic based at Children's Hospital Colorado (CHCO), was run by a pediatrician with breastfeeding expertise and designation in breastfeeding medicine (M.B.) and a lactation consultant with experience in primary care and neonatology (L.W.). Both saw patients together with the goal of providing focused, coordinated breastfeeding care during half-day specialty clinics. Previously, families received breastfeeding follow-up by phone or lactation specialists were called to see families in the outpatient clinics throughout the day. The consultations in the half-day specialty clinic were managed jointly by the pediatrician and the lactation consultant, who completed assessments and treatment decisions more efficiently. The lactation consultant would begin with a pre-weight on the infant while the pediatrician was wrapping up a prior case with a mother–infant pair and giving discharge instructions for home care and follow-up (Figure 1).

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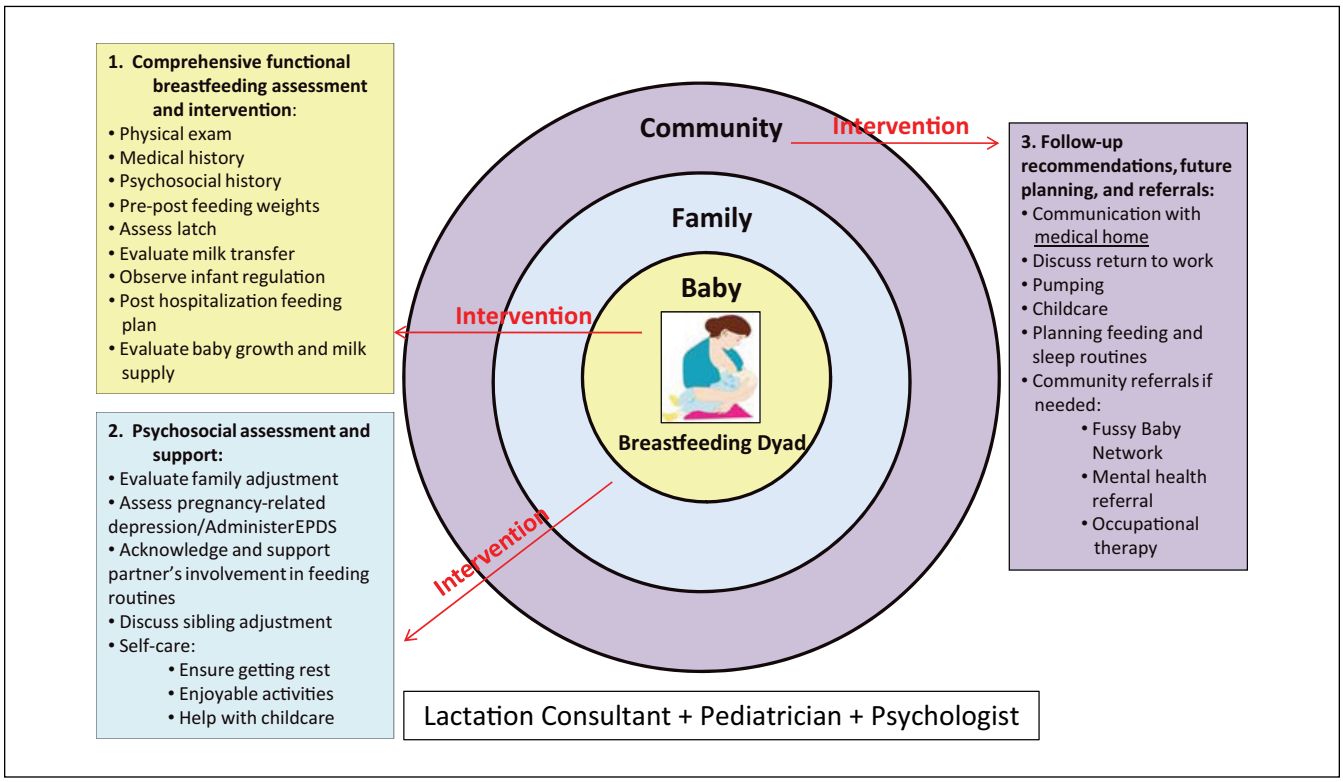
Figure 1. Trifecta Model of Care.



The BMC is located within the larger pediatric primary care clinic at CHCO, which has an established integrated mental health services program with on-site mental health providers who are available for consultation. Psychologists are available through Project CLIMB (Consultation Liaison in Mental Health and Behavior),[4] an integrated mental health program providing consultation and screening to patients during sick and well child visits. Because of Project CLIMB, BMC providers routinely screen for pregnancy-related mood disorders using the Edinburgh Postpartum Depression Scale (EPDS).[5] Grant funding for infant–parent bonding allowed the CLIMB team to dedicate 1 of the psychologists to work within the BMC.

Initially, it was not clear how to best integrate psychological services into the BMC. The psychologist (D.M.D.) began by observing consultation visits. With increased experience and understanding of the clinic flow, the psychologist also began giving supportive advice during visits. However, having 3 providers in the room at once felt both rushed and overwhelming for the families. In addition, it became clear that families needed time and space to discuss the social-emotional aspects of breastfeeding. Reflecting the needs of the patients and families, visits began with the medical team consultation (pediatrician and lactation consultant) and concluded with a debriefing and process-based conversation with the psychologist: the Trifecta Approach. Table 1 shows demographic information for the clinic.

The Role of the Pediatrician

The role of the pediatrician on the Trifecta team is to ensure a comprehensive approach and facilitate communication within the Trifecta. The pediatrician conducts a thorough maternal medical history including pregnancy and birth to ascertain any risk factors for breastfeeding difficulties and assesses the infant for immediate problems such as abnormal oral anatomy, neurologic tone, dehydration, or jaundice. Medication is reviewed for compatibility with nursing.[6] Routinely, pre- and post-feeding weights on the infant are used as 1 objective measure of the breastfeeding functional assessment, in combination with World Health Organization (WHO) growth curves. Although many breastfeeding dyads are referred for breastfeeding difficulties or slow weight gain, these concerns may be unrelated to low milk or issues with ineffective milk transfer at the breast. Clinical diagnoses that necessitate further follow-up or recommendations for medication are the pediatrician's responsibility (eg, prescription for mastitis or vasospasm of the nipple or pulmonary referral for concerns for the infant's respiratory difficulty).

Table 1. Top 12 Medical Topics Seen by Trifecta.

Rank	Medical Topic
1.	Sleepy infant
2.	Prematurity post neonatal intensive care unit (NICU) discharge, late preterm 36–38 weeks
3.	Multiples
4.	Fussy during nursing, pulling away, arching, associated with post-nursing spitting up, possible gastroesophageal reflux
5.	Overabundant milk supply or overactive letdown
6.	Maternal medications
7.	Fussiness
8.	Breast or nipple pain
9.	Never latched in hospital, bottle preference
10.	Nipple–mouth mismatch (mother with short, inverted, or generous nipples)
11.	Poor weight gain
12.	Low milk supply (perceived or real)

The Role of the Lactation Consultant

The lactation consultant shares responsibility for history-taking and medical problem solving. The lactation consultant's experience working with high-risk infants where establishing breastfeeding is challenging provides a helpful perspective in setting practical and realistic feeding goals with the mother and her family. Evaluation of latch and correct positioning are also key components to the goal of facilitating optimal milk transfer.

The Role of the Psychologist

Considering psychosocial and emotional health in the context of breastfeeding support is an integral part of the Trifecta Approach. The psychologist provides support and psychoeducation and conducts screening for pregnancy-related mood disorders as well as family functioning and adjustment. At the onset of the visit, mothers are asked to complete the EPDS. The heading on the form reads, "And how are you doing?" to encourage families to begin to consider how parental functioning and maternal mental health may be affected by the arrival of a new baby and the process of breastfeeding. The psychologist reviews the score of the EPDS and discusses them openly with each family.

The psychologist discusses and evaluates family adjustment, including how parents are managing their new roles and responsibilities, as well as assesses for sibling adjustment if appropriate. Examples of the themes addressed in each visit include assessing how families are co-parenting, managing sleep and feeding routines together, and functioning on very little sleep. The psychologist devotes a significant amount of time discussing and planning for maternal self-care with the ultimate goal of increasing maternal well-being and health, which directly affects ability to care for the infant.

At the close of a Trifecta visit, families receive a written list of steps to follow and a plan for the next week(s).

Trifecta Approach to Maternal Mental Health

In the context of a breastfeeding consultative evaluation, here are some examples of the concerns that may be addressed using the Trifecta Approach.

Lost Expectations: "Parenting Isn't Like I Imagined"

When anticipating breastfeeding, many families imagine content, blissful, and well-regulated infants who naturally take to the breast without complication or effort. Hopeful mothers and fathers often do not consider the myriad of psychosocial and emotional factors that may affect their experience as new parents. Families' experiences in the first few days of their baby's life are often markedly different from what they had imagined; consequently, they face lost expectations.

Pregnancy-Related Mood Disorders

Pregnancy-related depression affects as many as 19% of women in the postpartum period.[7] The self-resolving "baby blues" affect up to 85% of women in the postpartum period. The Trifecta Approach places high value on screening for pregnancy-related mood disorders, using the EPDS to provide an objective measure of how a mother is adjusting and coping with the transition to motherhood. A score greater than 10 on the EPDS, which is administered at each visit, is cause for concern. Discussing and reflecting the score back to the mother and family often generate additional details about maternal well-being, often revealing a history of a past pregnancy-related mood disorder, other mental health concerns, or significant psychosocial stressors. Anxiety in women of childbearing age is common, and childbirth itself is a significant life stressor, contributing to the prevalence of pregnancy-related anxiety.[8] Although it is less common than postpartum depression, many mothers present to the BMC with symptoms of anxiety. Unresolved depression and anxiety in mothers has been associated with early breastfeeding cessation[9-11] (Case Study A).

Grief

There are multiple ways in which breastfeeding and the experience of grief and loss overlap. Families who seek help from the Trifecta are often re-experiencing or grieving prior losses (eg, previous pregnancies). They are also often coming to terms with the discrepancy between their expectations about labor and delivery and the reality of having a premature or high-risk infant with medical complications, or of having insufficient milk supply.[12,13]

The Case of Baby A—Pregnancy-Related Depression

Baby A and her parents initially presented to the BMC when Baby A was 7 days old (born at 39 weeks gestation). Mother completed the EPDS and scored a 20, indicating high levels of sadness and anxiety. In the hospital, Baby A had difficulty latching and mother was instructed to pump and feed Baby A bottles to ensure her growth. Mother presented as exhausted from triple feedings—breastfeeding, pumping, and then feeding Baby A a bottle—and hoping to resume a "normal" breastfeeding relationship.

In the Trifecta visit, a functional breastfeeding assessment with the pediatrician and lactation consultant revealed that Baby A was a sleepy eater who had great difficulty latching onto her mother's generous-sized nipples. In only a week of life, it appeared as though the infant had come to expect a bottle of pumped breast milk following nursing to provide a quick and easy feeding after struggling at the breast. After struggling to stay alert and to latch, Baby A became fussy and her mother began to cry, handing Baby A to her father to feed her a bottle. The family developed a plan with the team to try a nipple shield and continue triple feeds to ensure Baby A's growth and work toward a successful latch.

Following the evaluation, the family met with the psychologist to process their experience and explore mother's sadness. After some discussion, Baby A's mother disclosed a long history of untreated depression, even before pregnancy, and, with her husband's support, agreed to seek mental health treatment. Pediatrician also called mother's primary care provider (obstetrician) regarding the high EPDS score to ensure that mother's issues could be addressed as well as the possibility of prescribing an anti-depressant.

The Case of Baby B—Prematurity and its Problems

Baby B was born at 34 weeks gestation to a first-time mom following an IVF pregnancy via vaginal delivery. Their initial Trifecta visit was on day of life 28 (post-gestational age 38 weeks). The infant's oral exam was significant for ankyloglossia (tight tongue frenulum) and she was scheduled for a frenulectomy (clipping by the otolaryngology specialist) the next day. Mother's EDPS score was 7; she commented that Baby B was very fussy and that she felt overwhelmed by breastfeeding, pumping, and caring for her infant. Her next visit was on day of life 35; she was now breastfeeding 4 feeds daily with the remainder bottle feeds of mom's expressed breast milk. EDPS score was 9 at this visit. Mother was still concerned at how fussy the infant was and that she was very difficult to calm. She remained strongly committed to ongoing breast milk feedings.

By day of life 75, Baby B was now full-term equivalent and still breastfeeding half of her daily feedings, so plans were made to increase feeds at the breast. EDPS score was 8 with, again, extensive discussion about infant fussiness. The Trifecta team recommended contact with the Fussy Baby Network Colorado, a community phone line and home visitation program, to receive more extensive support for managing Baby B's fussiness.

The follow-up visit at 2 months old revealed that Baby B was breastfeeding most feedings with only 1-2 bottle feedings of unfortified breast milk every 1-2 days. Despite recommendation not to, mother placed herself on an elimination diet removing both dairy and gluten from her daily intake but stated no changes in infant fussiness. With Baby B at 4 months of age, mother reported that the baby was thriving and that she was enjoying breastfeeding Baby B, stating that "the first 2 months of life seemed more like 2 years" to her due to the infant's ongoing fussiness.

Infertility

Many families seen by the Trifecta have struggled to conceive and stay pregnant. Once pregnant, caregivers may be emotionally exhausted from pregnancy, with little energy left to focus on the arrival of a new baby, including anticipating what it will be like to care for an infant, especially one with feeding difficulties. Although these families do not have higher levels of depression and anxiety postpartum, research suggests that they may present with less self-efficacy, self-confidence, and marriage satisfaction,[14,15] and report that their infants are more temperamentally difficult.[16]

Fussiness

Excessive crying often coincides with the establishment of the breastfeeding relationship, creating a complicated constellation of symptoms that are difficult to manage. Treating these infants typically requires several outpatient evaluations and medical detective work. Twomey and colleagues[17] describe the importance of addressing maternal mental health in the context of the management of the colicky infant. Mothers of breastfed infants have been found to be more affected by their infants' crying than formula-fed counterparts.[18] Moreover, breastfed infants are rated by their mothers as having more challenging temperaments[19] (Case Study B).

Financial Logistics

The cost of this half-day clinic includes 4 hours of lactation consultant salary. The physician salary is covered by charging professional fees to insurance companies. For the initial visit, co-payments are collected separately for the mother and the infant if required by their health insurance companies—on average, $30 each. Co-payments are collected only for the infant for subsequent follow-up visits.

Although this approach was developed with support for the psychologist's time from grant funding, most private insurance carriers are now paying psychologist fees as part of the bundled visit (D. L. Kaplan, Pediatrics Finance General at CHCO, personal communication, April 2013). Follow-up calls to assess satisfaction included 92% "excellent" and 3% "very good" ratings, and 88% found the psychologist helpful (data from Bryan Wallace, Professional Research Assistant, CHCO).

Conclusion

The Trifecta Approach offers a new model of care for the complicated process of breastfeeding evaluation and

support. Comprehensively and sensitively addressing the medical and emotional components, including stress, worry, and family circumstances, is challenging. Screening and assessing for pregnancy-related mood disorders is a critical aspect of the Trifecta Approach and should be included in replication efforts. Using a standardized screening tool enables providers to start the conversation about life with a newborn. We anticipate that these integrated models of care will have an increased presence in health care systems as reimbursement for lactation consultant evaluation, mental health services, and innovative models of care continue to emerge.

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Note

1. *Trifecta* is defined as a variation of the perfecta in which a person who places bets wins by selecting the first 3 finishers of a race in the correct order of finish. If a bettor predicts first, second, and third place in a horse race, it pays high dividends. The second definition includes an example of having achieved a show-business trifecta: a platinum record, a hit TV series, and an Oscar award for cinema. The word *trifecta* accurately describes our successful integration of 3 professionals from different disciplines in the provision of comprehensive and highly effective breastfeeding management services.[20]

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