Introduction

The World Health Organization recommends infants be exclusively breastfed for the first 6 months of life, with continued breastfeeding along with suitable complementary foods for up to 2 years or more. The American Academy of Pediatrics affirms that increased duration of breastfeeding confers significant health and developmental benefits for the child and the mother.

Human breast milk cannot be duplicated or mimicked. Undoubtedly breastfeeding provides the perfect combination required for growth, development and immunity of a human infant. Human breast milk provides immunologic protection shown to contain secretory IgA antibodies, lactoferrin, oligosaccharides, numerous cytokines and growth factors. The infant receives precisely the right amount of proteins, carbohydrates, vitamins, minerals, enzymes, antiviral, antibacterial, anti-allergens needed at their given stage of

CASE STUDY

Resolution of Breastfeeding and Latching Difficulty Following Subluxation Based Chiropractic Care: Case Report and Review of the Literature

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Abstract

Objective: The correction of a vertebral subluxation and resolution of latching and breastfeeding difficulty through chiropractic evaluation and low force adjustment is described.

Clinical Feature: A four-week-old female infant was brought in for chiropractic care by her mother. The mother was concerned that the infant was unable to effectively latch onto her left breast when held in the traditional cradle position or any other position.

Intervention and Outcome: Following a specific adjustment to the upper cervical spine and temporomandibular joint there was increased right rotation of the infant’s head and a decrease in left head tilt. Post palpation showed a decrease in hypertonicity of the right TMJ related musculature and the left cervical region. Breastfeeding was attempted immediately after the adjustment with success and no further issues remained.

Conclusion: The use of subluxation based chiropractic care showed positive results as described in the resolution of latching and breastfeeding issue in a four-week old infant. More research is warranted to fully understand the implications of early birth trauma and impaired function or dysfunction in breastfeeding. Craniocervical subluxation and temporomandibular imbalances are conditions to rule out when managing an infant with nursing dysfunction and inability to properly latch.

Key Words: Pediatric, breastfeeding dysfunction, latching, chiropractic, vertebral subluxation, adjustment

Introduction

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Breastfeeding & Latching Difficulty

The birth process drives maternal-infant interactions since during this period hormonal release helps to orchestrate the bond being formed. These interactions are designed to wire the mother and infant for attachment, directing them toward behaviors that optimize the infant’s potential, first for survival and ultimately for well-being. The ability of the infant to engage his mother and to initiate feeding at the breast is evidence of his biological and neurologic competency driven by primitive neonatal reflexes such as the rooting reflex and sucking reflex.

The Rooting reflex is a primitive reflex found in infants that causes them to turn towards a stimulus to feed when the side of their cheek is brushed. The sucking reflex is elicited by touching the lips or the skin near the mouth causing a sucking movement. Disruption to the proper function of either the musculoskeletal or nervous systems can therefore impact on an infant’s ability to breastfeed successfully. Successful breastfeeding relies on a series of complex movements facilitated by the craniofacial musculoskeletal anatomy. Imbalances or asymmetries in this delicate system have the potential to alter an infant’s suck and could possibly lead to nipple pain, breast engorgement, mastitis and insufficient milk supply.

Epidemiology

Epidemiological research reviewed by Wright, Schanler and Nutr, shows that more than two thirds of mother’s breastfed in the early 1900’s. Rates in the 1911–1915 cohorts were nearly 70% of women, and nearly 50% in the 1926–1930 cohorts; however, in the 1946–1950 cohorts, only 25% initiation rates were noted. A decline of 22% in mothers that breastfed their infants was reported in the early 1970’s. By 1975, however, breastfeeding initiation began to increase, from 33.4% in that year to 54% in 1980, and subsequently to 59.7% in 1984. Breastfeeding rates continue to rise, with increases of about 2 percentage points in breastfeeding initiation, and breastfeeding at 6 and 12 months. Breastfeeding initiation increased from 74.6% in 2008 to 76.9% in 2009 births. Breastfeeding at 6 months increased from 44.3% to 47.2%; breastfeeding at 12 months increased from 23.8% to 25.5%. According to the Center of Disease and Prevention, the goals of Healthy People 2020 are as follows:

Increase the proportion of infants who are breastfed
a. Ever - 81.9%
b. At 6 months - 60.6%
c. At 1 year - 34.1%
d. Exclusively through 3 months - 46.2%
e. Exclusively through 6 months - 25.5%
f. Increase the proportion of employers that have worksite lactation support programs - 38.0%
g. Reduce the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life - 14.2%
h. Increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies – 08.1%

According to research by Lau and Hurst, between 12.8% and 44% of infants reportedly experience suboptimal infant breastfeeding. The epidemiologic factors of feeding disorder have been monitored more as a function of specific disabilities such as stroke or Parkinson’s disease or cerebral palsy, cleft palate, AIDS, spina bifida, esophageal atresia, hypotonia, prenatal and postnatal brain injury, hydrocephalus, and mental retardation. Out of all the infants diagnosed with cerebral palsy, 40% will have a feeding disorder. Approximately 1 in 700 to 800 neonates are born with a cleft lip and palate defect. Infants suffering from AIDS have a 14% increase with significant feeding problems. Neurologic dysphagia that results from compression of the brain stem and lower cranial nerves (CN IX-XII) can occur in patients with spina bifida with an incidence rate of approximately 1 case per 1000 live births.

Medical treatment

If left untreated, feeding disorders can lead to failure to thrive as well as become a handicap that interferes with the patient's social, mental, and physical capabilities. It is possible for the effects of breastfeeding issues to have serious implications on the child later in life. For years doctors, nurses and even lactation consultants used alternatives in aiding the newborn's ability to receive milk from its mother; such as nipple shields, medicine droppers, spoon feeding and even early introduction of a bottle, which can then lead to nipple confusion thus furthering the difficulty of a mother and her newborn's success with breastfeeding. In addition, mothers are counseled on feeding with skin-to-skin contact and different breastfeeding position including the cradle hold, cross-cradle hold, football hold, side-lying position and Australian hold. Doctors, nurses and lactation consultants encouraged the mother to use what seems comfortable for her or her infant in order to achieve successful breastfeeding.

A few centers have developed such multidisciplinary feeding teams whose members generally come from such fields as nursing, nutrition, occupational therapy, speech therapy, pediatric gastroenterology, psychology, and lactation counseling. Treatment protocols are performed with practitioners in neurology, pediatric surgery, developmental pediatrics, diagnostic imaging, or physical therapy.

The following are a possible sequence of events for the diagnosis and clinical management of a patient with an infant who is unable to latch and feed:

1. Medical history
2. Physical examination
3. Lactation consultation
4. Radiological and physiological tests
5. Feeding trial
6. Follow-up and adjustment

The diagnosis and treatment of feeding disorders in infants is a complex and multifaceted process. It requires a multidisciplinary approach involving a team of professionals with expertise in pediatrics, pediatrics, nutrition, speech therapy, occupational therapy, and lactation counseling. The ultimate goal is to promote optimal feeding and growth, while minimizing the impact of feeding disorders on the infant and family.
1. Medical history is taken with an emphasis on history of feeding dysfunction, related surgeries, and former treatment plans, if any.
2. Nutritional evaluation is conducted by the dietitian and dietary corrections are made.
3. Feeding evaluation is performed by the occupational or speech therapist who evaluates the nonnutritive and nutritive oral-motor aptitudes of the patient.
4. If abnormal swallowing is suspected, a videofluorography is performed with the interpretation of the test normally conducted by the speech therapist.
5. If a gastrointestinal disorder is suspected, the pediatric gastroenterologist is consulted.
6. If behavioral concerns need to be addressed for parents or infant, the clinical psychologist is consulted.
7. Meeting of the team members is conducted to discuss their respective observations. Areas of concern that need to be addressed are prioritized, and a treatment recommendation is made.
8. Follow-up and reassessment of therapeutic program are necessary to verify efficacy of the treatment plan. In the treatment of feeding disorders, the continuous involvement of the primary care physician and the patient's family are of primary importance.

**Chiropractic Care**

Chiropractic is based on the concept that restriction or misalignment of the joints of the spine may disrupt optimal nervous system function which is then transmitted to the organs that these nerves control resulting in symptoms and disease.14,15

According to the chiropractic literature, the mechanical alterations can lead to latching issues. The following biomechanical problems are responsive to chiropractic care:3

1. Altered tongue action resulting in ineffective latch
2. Decreased mandible excursion preventing wide mouth opening
3. Hypotonic suprahyoid muscle group preventing sufficient mouth opening
4. Displaced hyoid preventing balanced tongue activity
5. Aberrant cervical range of motion and/or posterior joint restrictions affecting infant posture and position
6. Hypo or hypertonic orbicularis oris, masseter, digastric muscles causing imbalance in muscle torque
7. Temporomandibular joint laxity or imbalance
8. Mechanical changes in neural function relative to cranial or cervical distortion

Throughout the literature intrauterine constraint, the birth process, interventions/assisted delivery and birth trauma of the neonate may all contribute to alterations in structure that affect normal function of latching. The chiropractor will assess neurologic integrity (including infantile reflexes like rooting and suckling, suck, swallow, breath synchrony and other neurologic milestones (eye contact, response to sensory stimuli, etc), cranial, spinal and extraspinal joints for stability and range of motion as well as cerebral spinal fluid rhythm, and finally muscle length, tone and symmetry or asymmetry.12 Management may include myofascial release of associated soft tissue structures (cranial and submandibular, cervical and tongue muscles), adjustments to the individual cranial bones and spinal vertebrae, lymphatic drainage and light massage techniques and specific stretches or range of motion exercises as indicated.12

Children showing abnormal cranial molding after birth, meaning a dent or uneven bulging in the skull or a sutureal line that is prominent, may affect the ability of the cranial bones to move properly.16 Consequently the effect of cranial molding may alter the sucking response or make the child uncomfortable in certain positions when attempting to nurse.16 Craniosacral therapy (CST) is a gentle, noninvasive, yet effective type of hands-on body treatment that is helpful, in monitoring the cranio-sacral rhythm.14 CST is a form of adjustment using light pressure applied with the hands to restore movement in distorted cranial bones and improve restricted motion to related soft tissues.

**Case Report**

**History**

A four-week-old female infant was brought in for chiropractic by her mother. Care was recommended by a lactation consultant because the mother was unable to get an appointment for consult until the following week. The mother was concerned that the infant was unable to effectively latch onto her left breast when held in the traditional cradle position or any other position.

**Examination**

The infant was otherwise healthy with normal behavior, respiration, head size and no facile asymmetries. All neurological and orthopedic tests were unremarkable and within normal limits. The infant had postural abnormalities of a slight (few degrees off normal) left lateral lean or head tilt to the left. Palpation of the infant’s muscles revealed hypertonicity in the right temporomandibular joint (TMJ) and the left cervical dorsal area.

Multiple subluxations with spasm, hypomobility, and endpoint tenderness were found at the right sacrum, the fifth dorsal vertebrae (T5), the right atlas (C1), and right TMJ. According to Stephenson’s 1927 text, the following must occur for the term “vertebral subluxation” to be properly applied:17

1. loss of juxtaposition of a vertebra with the one above, the one below, or both
2. occlusion of an opening
3. nerve impingement
4. interference with the transmission of mental impulses

For the purpose of this article, the term subluxation refers to apparent misalignment of a bone relative to adjacent
structures, as evidenced by asymmetry and joint fixation.\textsuperscript{18}

**Intervention**

The patient was managed by using a full spine Diversified chiropractic technique and an infant toggle head piece for the C1 subluxation. Dr. Larry Webster created the infant toggle headpiece by combining elements of B.J. Palmer’s upper cervical work and J. Clay Thompson’s drop table. This specialized headpiece provides a specific, low force adjustment for the child’s upper cervical subluxations as well as in cranial work.\textsuperscript{19} The headpiece delivers an effective but reduced drop with an adapted cervical drop mechanism, allowing the adjustment to be gentle with a low force. On the initial visit the infant received her first chiropractic adjustment. A toggle head piece was used for the Atlas with a lateral drop with a straight right to left line of drive. The right TMJ was adjusted using a sustained contact with the line of drive using a straight inferior pressure.

**Outcome**

Post visual analysis of the infant’s cervical region revealed increase right rotation of the infant’s head and decrease in left head tilt. Post palpation showed decrease of previously noted hypertonicity of the right TMJ and left cervical region. Breastfeeding was attempted immediately after the infant adjustment. The mother reported the baby was able to latch perfectly and nursed without interruption for 30 minutes. The infant was schedule to be seen twice a week until latching issue was completely resolved. The mother returned the next week and reported total resolution of the infant’s inability to latch on her left breast.

**Discussion**

**Mechanics of Breastfeeding**

In order for an infant to achieve successful nursing and latching the mechanics needed for sucking, swallowing, and respirations must be mastered. These simple actions rely on a series of complex movements facilitated by the craniofacial musculoskeletal anatomy. A newborn infant uses half of its cranial nerves, twenty two bones connecting at thirty four sutures; and sixty voluntary and involuntary muscles to suck, swallow and breathe in a coordinated activity.\textsuperscript{15} This process occurs at eight to sixteen times a day for ten to thirty minutes per feeding and at forty to sixty cycles per minute.\textsuperscript{12,20}

Dysfunction may lead to impairment putting the infant at risk for aspiration, pneumonia, oxygen desaturation, apnea, and bradycardia. Efficient sucking relies on the proper integration and timing of the activity of the lips, cheeks, tongue, and palate in the formation of a bolus and its propulsion to the back of the oral cavity for swallowing.\textsuperscript{10} Safe sucking relies on the coordinated activity of oropharyngeal muscles for the protection of the airway into the esophagus. The central rhythm/pattern generator (CRG) coordinates these functions of sucking, swallowing, and breathing and the cranial nerves that control different aspects of these actions.\textsuperscript{12}

Research has suggested that the CRG is located in the vicinity of the respiratory center in the region of the nucleus tractus solitarius and nucleus ambiguous.\textsuperscript{12} The cranial nerve arise from the medullary portion of the brainstem and exit through multiple locations on the skull. Where they control either the motor or sensory aspects needed for sucking, swallowing, and breathing.

It has been proposed that the coordination of the pharyngeal musculature for proper swallowing requires the activation of the medullary swallowing center, a central pattern generator, in the brainstem.\textsuperscript{12} This center, receiving inputs from the cerebral cortex and peripheral muscles, can induce voluntary and involuntary swallowing. During infant feeding, stimulation of the swallowing center is believed to require an external input, such as the formation of a bolus, unlike the sucking center, which may not need an external stimulus for activation.

According to Lau and Hurst, closure of the trachea at the level of the epiglottis, aryepiglottis, and true and false vocal cords must occur when the bolus enters the pharyngeal cavity and the upper esophageal sphincter relaxes to allow passage of the bolus into the esophagus to prevent aspiration. The swallowing process possesses a certain degree of plasticity: during a feeding, as the size and/or texture of the boluses constantly vary as well as the head and neck postures, maintenance of a safe swallow necessitates a constant adaptation of the pharyngeal musculature.\textsuperscript{12}

**Possible Causes of Breastfeeding issues**

According to Vallone, the ability to suckle in a newly delivered, full term infant, may be impaired or disorganized due to neurologic immaturity (gestational age) or a mild to severe neurologic or musculoskeletal problem as a result of several possible situations:\textsuperscript{21}

1. Injury (as a result of traction/manipulation/intervention either manually or with forceps or vacuum suction).
2. Asphyxiating (premature placental separation/cord entanglement/etc.)
3. Congenital deformities like a high palatal arch, cleft palate, ankyloglossia or an anatomically short tongue.
4. A genetic developmental disorder like Pierre Robin or Down Syndrome.
5. Pharmacologic suppression by drugs administered to the mother during childbirth.
6. Invasive procedures to clear meconium, gastric lavage, or insertion of an airway which could result in oral aversion.

These biomechanical or neuromuscular problems could include:\textsuperscript{21}

1. Decreased excursion of the mandible preventing the neonate from opening widely enough to encompass the nipple and areola.
2. Decreased cervical range of motion, which affects ability to position themselves comfortably in their mother’s arms or at the breast.
3. A neurologic deficit manifesting as a lack of sucking or rooting reflexes.
4. An ineffective latch due to altered lip or tongue action.
5. Impaired respiration (restriction in thoracic excursion or diaphragmatic action or lack of patent airway).
6. A rapid milk ejection reflex (MER) or overabundant milk supply might result in compensatory muscle action (clenching, etc.) to modulate milk flow.

Birth Trauma

Tutt and Mesidor, reported that birth trauma occurs in 29 out of every 1000 births in a hospital setting. Roughly 2.6% of births are complicated by some type of birth trauma resulting from mechanical forces such as compression, distraction, or torsion. As mentioned by Slak and Wilson, these forces can greatly reduce cervical range of motion, create neurologic deficit; manifest as interference of the cranial nerves and the inability to latch due to disruption of the cranium. Birth trauma can cause several different injuries to the neonate, including but not limited to, brachial plexus, torticollis, and deformational plagiocephaly secondary to external force. Birth trauma may be triggered through assisted delivery with forceps or vacuum extraction, caesarian delivery, malpresentation, and epidurals. Signs of trauma range from hemorrhage, cephalohematoma, forceps scars, asymmetric occlusion, facial nerve palsy, brachial plexus injury, fractured clavicle, and severe jaundice.

The birthing process involves lateral flexion, rotation, and traction to the upper cervical spine, along with a great deal of axial compression followed by distraction. During the normal process of birth the newborn infant’s skull can be exposed to mechanical forces which may affect the bony configuration/alignment of the skull, compress brain and central nervous system structures and disrupt nerve function or cause nerve entrapment.

The working diagnosis of cervicocraniomandibular syndrome indicates the known relation between the jaw, cranium, and cervical spinal column. The term cervicocraniomandibular syndrome denotes the potential of the TMJ, cranial articulations, and upper cervical spine to influence one another. In the infant, the cranial bones are more mobile in the adult and are separated by wide strips of cartilage; their relative positions shift during vaginal birth.

Interference with these structures can alter the biomechanics of breastfeeding. Spinal or cranial lesion may lead to improper nerve supply to the involved anatomical components therefore affecting the infant’s ability to breastfeed. It is important for clinicians to recognize and address simple biomechanical reasons for breastfeeding dysfunction as it is to recognize more complex cases with multiple concomitants; for example, subluxation, tongue tie, developmental delay, and cranial deformation.

Cranial Nerve V

The trigeminal nerve contains sensory fibers from the palate, tongue, lower jaw, nose, and motor fibers that control some muscles used in mastication(temporals, masseters, internal and external pterygoids). Coordination between perioral muscles and TMJ function has been found to be important for proper sucking, tongue action, and jaw lowering play primary roles in producing good sucking strength. Hypertonicity of TMJ related muscles, such as the temporalis, could result in spasm and thus in painful headache when sucking was attempted. Subluxation, or misalignment and dysfunction of the TMJ itself may elicit pain itself when sucking is attempted. The scientific literature has drawn more links between the function of the upper cervical spine and head and headache pain; perhaps as a result of upper cervical and/or cranial subluxation. Pain fibers of the trigeminal nerve originate from receptors in the scalp, skull, meninges, and vessel walls within the brain. Traction on these fibers produces pain, therefore it is plausible that a preexisting cranial subluxation would be worsened by sucking efforts. Furthermore, the tension on the nerve may result in headache pain for an infant when attempting to latch and breastfeed.

Cranial Nerve VII

The facial nerve (CN VII) contain sensory fibers from the palate, anterior two-thirds of the tongue, and tear ducts; and motor nerve that innervate the facial muscles, lips, cheeks, and jaw. Motor fibers of the cranial nerve VII are involved in rooting, latching, and the sucking response. The infant’s suck response is triggered in part by tactile receptors in the lips and palate. The primitive reflexes of rooting and sucking are present at birth and essential for successful nursing. The facial nerve exits the cranium emerging through the stylomastoid foramen. This foramen is located along the suture of the temporal bone between mastoid process and styloid process. During the birth process when cranial molding occurs there is a probability that nerve interference may occur causing dysfunction and possible impairment with breastfeeding.

Cranial Nerve IX, X, and XI

Passing through the jugular foramen between the temporal and occipital bones are three cranial nerves that affect suck, swallow, and/or breathing. The jugular lies between two segments of the occipital and three segments of the temporal bone. In theory, misalignment of the bony segment following traumatic birth events can affect nerve function in any or all three nerves. The glossopharyngeal nerve (CN IX) has sensory fibers from the posterior palate, the pharynx muscles and tongue which controls the gag response.

Hyper-responsive gagging can inhibit latching on the breast. The Vagus nerve (CN X) has motor fibers to the muscles of the soft palate, larynx, heart, lungs, trachea, and gastrointestinal tract; and sensory fibers from the lungs, trachea, bronchi, larynx, pharynx, gastrointestinal tract, and external ear. The Vagus nerve controls breathing and heart function. Any interruption of vagal function could interfere with suck-swallow-breathe coordination. The spinal accessory nerve; controls the sternocleidomastoid and trapezius muscles, therefore involved in torticollis, head position and airway patency - all known to affect sucking, swallowing, and breathing.
Cranial Nerve XII

The hypoglossal nerve (CN XII) governs the motor functioning of the tongue.1,5,20,22 Cranial nerve XII pass through the space between the condylar and basio segments of the occiput; therefore pressure at this point could disrupt the hypoglossal nerve. During cesarean surgery, the surgeon’s hands lift the infant’s skull out of the uterine incision by placing pressure on the two condylar segments of the occiput located at the cranial base.

Subluxation Due to the Birth Process

Kent discusses the dysafferentation model which states how the neurological dysfunction associated with the vertebral subluxation may cause biomechanical dysfunction due to alteration in normal nociception and/or mechanoreception of intervertebral motion segments. The biomechanical dysfunction results in aberrated afferent input to the CNS leading to dysponesis.23 Dysponesis is defined by Dorland’s Medical Dictionary as follows: “a reversible physiopathologic state consisting of unnoticed, misdirected neurophysiologic reactions to various agents (environmental events, bodily sensations, emotions, and thoughts) and the repercussions of these reactions throughout the organism. These errors in energy expenditure, which are capable of producing functional disorders, consist mainly of covert errors in action-potential output from the motor and premotor areas of the cortex and the consequences of that output.”23

Hewitt reviews three proposed mechanisms for altered cranial nerve function:24

1. Direct compression of the cranial nerves or medulla by abnormal cranial bone motion. Nerve compression has been shown to decrease nerve conduction velocities, decrease axoplasmic flow and create motor disturbances in related muscles.24

2. Somato-autonomic reflexes caused by cervical subluxation could cause a change in vascular supply to the contents of the cranial vault affecting cranial nerve function or it may directly affect the superior cervical ganglia which communicate directly with the CN IX, X and XII, potentially altering their function resulting in abnormal suckling.24

3. Cranial and cervical subluxation result in increased traction and tension in the dura mater potentially resulting in constriction of the dural sheath of the cranial nerves altering nerve and end organ function.2,21,22,24

Cranial molding takes place during the vaginal birth process; the baby’s head is shaped during forced labor as it is squeezed through the birth canal.1,5,22 The bones of the skull may become overlapped at the suture lines causing elongation or asymmetry of the infants cranium.12,20

During an instrumental or assisted birth with the use of forceps there is a possibility for bruising and nerve damage depending on placement of the forceps. This may cause the infants jaw to deviate to the paralyzed side when the mouth is opened and therefore impede the newborn infant’s ability to latch and suck.12,20 The temporal bone, sphenoid, maxilla and mandible are pushed caudally, possibly causing severe spasm in all muscles of mastication.12 This chain of events has the potential to lead to breastfeeding problems and may be directly caused by temporomandibular imbalances.21

Conclusion

The use of subluxation based chiropractic care showed positive results as described in the resolution of latching and breastfeeding issues in a four-week old infant. Cranio cervical subluxation and temporomandibular imbalances are conditions to rule out when managing an infant with nursing dysfunction and inability to properly latch on the mother’s breast.

Chiropractic adjustments safely and effectively eliminate cranio cervical dysfunction and restore natural, efficient suckling patterns for infants with neuromusculoskeletal presentation.25 Clinicians have the responsibility to have an open dialog with OBGYN’s, midwives, pediatricians, lactation consultants, and other healthcare providers. The goal is to help improve not just the physical health of an infant but to enrich their overall wellbeing. Chiropractic care when applied skillfully and in collaboration with other providers can support full competency in feeding and offer the infant the opportunity to reclaim his/her full potential.26

References


