Better Breastfeeding with Dr. Linda Dahl

Episode 290 · July 7, 2022 · with Dr. Linda Dahl

IN THIS EPISODE

ENT surgeon and breastfeeding expert Dr. Linda Dahl has seen breastfeeding struggles from both sides — as a clinician, and as a mother who lived them. She shares with Dr. Elliot Berlin, DC the new approach she's developing to assess and support mothers and babies at any stage of the journey.

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DR. ELLIOT BERLIN, DC: Welcome to the Informed Pregnancy and Parenting Podcast. I'm your host, Pregnancy-focused carpenter, Dr. Elliott Berlin. My guest today is a mom, an author, an ENT surgeon, and a breastfeeding expert currently developing a new paradigm in breastfeeding to help assess baby and mother's breastfeeding experience. Dr. Linda Dahl, welcome to the podcast.

DR. LINDA DAHL: Hi, Doc. Thanks for having me.

DR. ELLIOT BERLIN, DC: Oh, I cannot wait to learn from you. You have such an interesting background on where you came from and what you experienced and where you headed and where you are now and are still heading. So that's a mouthful. Let's start at the beginning. Where are you from originally?

DR. LINDA DAHL: I was born in Texas, but I grew up mainly in Minot, North Dakota.

DR. ELLIOT BERLIN, DC: Okay. What was that like? Because is anybody else there? Is that where the Rushmoors or is that South Dakota?

DR. LINDA DAHL: That's yeah, the Dakotas get mixed up all the time. So South Dakota is the more famous of the Dakotas. North Dakota has the Badlands, but very little else. And then it had fracking for a moment, which is now famous for fracking. I guess despite the fact that it's pretty desolate and flat and freezing, it was made even more bizarre by the fact that my parents are immigrants from Syria, the country, you know, long before the war. They chose Minot, North Dakota. I have no idea why. So I ended up growing up in this very tiny farm town that was frozen 90 miles from the Canadian

border. Syrian immigrant parents. So it was very interesting.

DR. ELLIOT BERLIN, DC: So not a huge Syrian community.

DR. LINDA DAHL: Basically, nobody. No Syrian community. No. And it was hard, you know, because we traveled a lot. We lived in Jordan when I was seven and I knew there was a world out there. So I knew living in North Dakota, there was a lot more to the world. So, you know, it affected my perspective on living there and on my parents. And I just kept saying, I just have to make it till I can get out of here and then I'll go out into the rest of the world. It'll be fine. And that's what happens.

DR. ELLIOT BERLIN, DC: Sometimes I wish I was in the middle of no place in North Dakota.

DR. LINDA DAHL: Sometimes until the wintertime comes and then you don't want to be.

DR. ELLIOT BERLIN, DC: Right. I would probably just hibernate like a giant bear.

DR. LINDA DAHL: Yeah. And sometimes the snow drifts would close us into the house. We couldn't leave the house.

DR. ELLIOT BERLIN, DC: Like you couldn't open your door.

DR. LINDA DAHL: We couldn't open the door.

DR. ELLIOT BERLIN, DC: Wow.

DR. LINDA DAHL: Because it's all planes. Yeah, it's planes. It's flat. So there's nothing to buffer the snow drifts. You know, we'd have, have a really bad snowstorm. It would sometimes block up the door and then it would go into deep freeze. It would get to 80 below zero. So there was, you couldn't leave the house literally.

DR. ELLIOT BERLIN, DC: So lucky.

DR. LINDA DAHL: Just talking about it.

DR. ELLIOT BERLIN, DC: I've been talking about it. I felt trapped when I'm in Hawaii. Yeah.

DR. LINDA DAHL: You'd like it in North Dakota.

DR. ELLIOT BERLIN, DC: I don't think I'd like it anymore. I just, I wanted some quiet for a minute, but I'll just go into my meditation room. Okay. Now you're not there anymore. Where do you live now?

DR. LINDA DAHL: I live in New York city now, and I've been in New York for 24 years.

DR. ELLIOT BERLIN, DC: Are you multilingual?

DR. LINDA DAHL: Not really. My parents wanted us to grow up Americans. They gave us American first names and they only spoke Arabic when they were trying to tell each other secrets or swear at us. So no, I trained in the Bronx. I learned, you know, enough Spanish to get by medically, but that's it.

DR. ELLIOT BERLIN, DC: So mostly English. Okay. So when did you start thinking medicine?

DR. LINDA DAHL: I wanted to be a costume designer and my father decided medicine basically when I and all my sisters both came out of the world and he ended up with two of us, two doctors. So we were told from the moment we understood words that we were going to go to medical school. So it was really more that than anything, but I really loved costuming and art and I got into medical school in college. And then I gave up my acceptance to do costuming for a couple of years and then reapplied and ended up going back to medical school at the university of Minnesota.

DR. ELLIOT BERLIN, DC: Minnesota. Cause you were used to the cold.

DR. LINDA DAHL: Cause I was used to the cold and it was a huge city in Minneapolis. It was diverse compared to North Dakota.

DR. ELLIOT BERLIN, DC: Okay. So then now you're an ENT, your nose and throat surgeon. How did you choose that specifically?

DR. LINDA DAHL: It was when I went to medical school, I didn't even know what it was as a specialty, but it really combined all of my favorite parts of the body and it was more complex. You know, the anatomy was more complex than anything I could understand as a medical student. So I knew it would keep me interested. And I also loved that it was one of the rare specialties where I could take care of people of every age. So from babies who are newborn to, you know, people at the end of their life and combinations of people, pregnant women. I mean, it's kind of like being a family practice doctor, but I could also do surgery, but it's just above the clavicles.

DR. ELLIOT BERLIN, DC: Above the clavicles. You seem like the neighbor. Everybody would go to for a little.

DR. LINDA DAHL: Thanks. That's what I feel like even in New York city.

DR. ELLIOT BERLIN, DC: That's a lot of neighbors in New York city. It's a lot of neighbors. Okay. So is your practice even as it goes ENT, do you have a specific approach to ENT or to medicine in general?

DR. LINDA DAHL: Uh, I think that my approach to medicine is much more holistic. I mean, naively, when I went to medical school, I thought it was really just about healing prevention and healing and really bringing the body back to, you know, its natural ability to take care of itself and heal itself, but you know, in my naivete, I didn't realize that medical school is medicine and surgery, like giving people drugs and cutting things out of them. So, you know, I went through medical school and residency, which is very hard for me, I think more so than most other people. But when I went into practice, I knew I couldn't be part of a hospital system. And if I was going to be able to practice in a way that worked for me, I would have to be on my own.

DR. LINDA DAHL: So I've been in solo practice most of the time, but I really have an integrative approach to ENT and I, I take care of the whole person, um, but the ear, nose and throat are the way it's just my entrance into the body. So that's kind of how I, you know, have to figure out what's going on with them. But most of the time, the answer to what's happening, what's wrong, the reason they're coming in to see me is much bigger than just their ears, noses and throats.

DR. ELLIOT BERLIN, DC: You mentioned the full spectrum of age, of life, newborns all the way through end of life. What specifically do little babies and infants come to see you for?

DR. LINDA DAHL: Now they specifically come to see me for difficulty breastfeeding. And that started, um, I was hired by a group of pediatric ear, nose and throat doctors right out of residency. And I had just given birth to my daughter who was six months old and she couldn't breastfeed. And I went through, you know, I think what most women go through when they have trouble breastfeeding, you know, losing the milk and the pain and trying to get help from doctors, but not really getting any help from anybody. And then ultimately I failed and I lost my milk and it was very emotionally traumatizing for me. So I joined this practice and a lot of the referrals to them were for babies that couldn't breastfeed.

DR. LINDA DAHL: And I immediately took an interest and kind of took over all those babies and found ways to help them breastfeed.

DR. ELLIOT BERLIN, DC: Okay. So that's kind of how I started by talking about the unusual path that you took to get to where you are, which we're just warming into. And then the unusual practice that you have now and how you can even help people who are not in New York city. Let's take a little break. When we come back, we'll find out more. Welcome back to the informed pregnancy podcast. We're talking to Dr. Linda. Okay. So you said your residency was harder for you than most. Why is that?

DR. LINDA DAHL: Well, I think I had a harder time compartmentalizing. I really just got very connected to the patients and their suffering and it was hard for me to, you know, look at everything as objectively, I think as most doctors and I think too, like a lot of, you know, allopathic doctors. I read a statistic once that 90% of doctors come from other doctors. So I think there's a way to go through the training where you kind of protect yourself, but also think of the patient as a separate, you know, person, and they kind of objectify them a little bit, but I was just very bad at doing that. So it was emotionally really hard for me. I mean, I cried every time my patients passed away, you know, I was advocate for them in a way that was,

DR. LINDA DAHL: you know, kind of irritating to the other doctors in the hospital. So it was really much more personal for me.

DR. ELLIOT BERLIN, DC: Yeah, it sucks to have a big heart, especially if you're going to be a surgeon, bad idea. You know, when I was much younger, I worked in ambulances and emergency rooms and started when I was 17 and 18 and at that point I felt so invincible. Like it's almost like very disconnected from patients emotionally. First of all, you don't get to develop a relationship with them. It's like, hello, emergency, stabilize you and pass you off. But, you know, even when really terrible things were happening, I think it was the opposite for me in my mind. It was just like, I got to be the best plumber. I could be on this plumbing unit and do the best job I can. And it wasn't until later that I started to get a little bit more attached.

DR. ELLIOT BERLIN, DC: Uh, we did lose a patient who was the same age as me, a 21 year old. And it was a little traumatic for me. And then after that, I had a much harder time. That's the point I was trying to make. So that's when I could start to relate to you and how much more difficult it is when

you do care and you get attached and, you know, now you're not just a plumber.

DR. LINDA DAHL: Yeah. And it really, you know, it never went away. It never got easier for me. So when I would see the mothers that were suffering, when they would come in, I think I was more willing to, you know, go outside of my comfort zone and go outside of my specialty's comfort zone to try to come up with solutions for them because it is really hard to watch people suffer. Sure.

DR. ELLIOT BERLIN, DC: You have a baby in the heat of your medical training. Was that a conscious choice?

DR. LINDA DAHL: Oh, no, not at all. I watched the other females in surgical practice, there were very few of us, but I watched them go through pregnancies. And I knew absolutely certainly that I was not going to go, and I was married at the time and it was a surprise, you know, to be honest, I was actually applying for plastic surgery fellowships and I found out I was pregnant and then I knew that that wasn't going to happen. Yeah. So it was definitely not planned.

DR. ELLIOT BERLIN, DC: I would have guessed plastic surgery for you because, well, just cause you want to do costumes and it's sort of like the ultimate.

DR. LINDA DAHL: True, true. I'm grateful that I don't do that now.

DR. ELLIOT BERLIN, DC: So, I mean, I imagine pregnancy during residency must've been insane. And then, I mean, it seems hard on both sides, like it would mess with your progress in your intense training medically, and then also be a bit hard to carve out time to take care of yourself while during the pregnancy, take off time for birth and, you know.

DR. LINDA DAHL: Well, they only gave us six weeks of leave and that's because you only got six weeks off of residency, no matter what the reason was. And if you missed more than six weeks, you had to repeat the whole year. So that was very hard. And so I had to work until the day I gave birth, which was 10 days overdue. It was enormous. The delivery was so traumatizing and awful, but the hardest part of all was having to leave her after six weeks.

DR. ELLIOT BERLIN, DC: I assume you had already done OB rotations.

DR. LINDA DAHL: No, I didn't do OB rotations as a resident. I did them as a medical student.

DR. ELLIOT BERLIN, DC: Yeah.

DR. LINDA DAHL: So I kind of knew earlier than that.

DR. ELLIOT BERLIN, DC: Yeah. Yes. So you had experience with delivery of other people. I'm sorry to hear that was a very tough experience for you. Did you have sort of a loose plan formulated going in?

DR. LINDA DAHL: Oh yeah. I had a great plan. I mean, I was also very active. I'd run ultra-marathons. I was like very physically fit. I could take pain and I was prepared to have a natural birth. I didn't want pain medicine. I was, you know, ready to go, but unfortunately I found out later, I had a placental abruption and like her cord was wrapped around my daughter's neck. So it went very quickly. So for my first contraction to full dilation, I think was like less than two hours when I started

pushing a first baby. So nobody believed I was actually going to have the baby. They kept trying to discharge hospital. I'm just like, this is labor. And they kept saying, didn't you take Lamaze? I was just like, there was no break between contractions.

DR. LINDA DAHL: It was just like one after the other. Then my water broke and then they took me seriously. And it was actually thanks to an in-house OB obstetrician who trained in Canada because he knew how to use forceps. And when she was starting to crown, her heart rate went all the way down. So he just came in with forceps and just, you know, we got her out of it. That's how she was born from the first contraction to her birth was in three hours. It was really fast.

DR. ELLIOT BERLIN, DC: Is that a lot of tearing?

DR. LINDA DAHL: That was horrifying. No pain medicine. I mean, and it wasn't like forceps. I don't know. People realize it's not about pulling the baby out. It's about ripping you open so the baby can come out.

DR. ELLIOT BERLIN, DC: Yeah. So that's what I'm saying. You must've had a lot of tearing.

DR. LINDA DAHL: Oh, it was, yeah, it was layers and layers, but everything healed and it was, you know, I think more emotionally terrifying than physically later.

DR. ELLIOT BERLIN, DC: I mean, it was practically your neighbor from 90 miles north of growing up.

DR. LINDA DAHL: That's true. I was lucky for that. Thank you for making that connection. I never really did. Well, Dr. Bebbington, Dr. Bebbington, that was his name is my savior.

DR. ELLIOT BERLIN, DC: So is it that we don't really train on forceps that much anymore? It's more about the vacuum now or?

DR. LINDA DAHL: I think it's more about the vacuum now. Yeah. And there's no way the vacuum wouldn't have worked for her because the residents were trying it and my obstetrician didn't believe I was in labor. So she wouldn't even come in. So the residents begged this, you know, in-house obstetrician to come deliver my baby. And it's funny when he came in, I thought he was the anesthesiologist and I thought, oh great, I'm going to get the epidural. Like, no, no, I'm going to do the opposite of that.

DR. ELLIOT BERLIN, DC: Yeah. And then placental abruption just since you mentioned it. So that's where the placenta becomes traumatized or starts to...

DR. LINDA DAHL: It detaches too fast. Pulls off the wall too quickly. Yeah, it pulled off the wall too quickly.

DR. ELLIOT BERLIN, DC: Boy, that sounds scary, dangerous, physically and emotionally not comfortable.

DR. LINDA DAHL: And then to go from that into not being able to breastfeed was just, it was very hard. And then during a time when I didn't really have time or space or money or support to really, you know, make it any better than it was.

DR. ELLIOT BERLIN, DC: Right. I mean, six weeks seems like a slim margin when everything goes just perfect.

DR. LINDA DAHL: Yeah. And, you know, and it was like that for all the female residents.

DR. ELLIOT BERLIN, DC: Okay. Breastfeeding was challenging for you. Do you know why?

DR. LINDA DAHL: I now know why because I figured it out. I mean, I've been in practice now 19 years, but it took me 11 years in practice to finally understand the dynamics of breastfeeding and really understand why it didn't work for me.

DR. ELLIOT BERLIN, DC: Before we get to like the diagnosis, let's say, what were the mechanics of it? Not working. Were you not making milk? Were you not able to latch? Was the baby?

DR. LINDA DAHL: Yeah. I mean, it's all interrelated. Right. So for the first four weeks, she was attached to me 24 seven. And if she wasn't nursing, she was sleeping or crying. And I remember I couldn't go for more than an hour away from her because she was awake, she was eating or she was nursing and it was extraordinarily painful and you know, lots of trauma. And I thought she was getting milk. She seemed like she was getting milk, but she was hungry all the time and it was hard to interpret her cues. You know, people use the terms cluster feeding and, you know, your colostrum comes in, you know, I could kind of deduce from all the information I have that maybe this was normal. And I kept, you know, asking my pediatrician and my obstetrician, is this

DR. LINDA DAHL: normal? Is this what it's supposed to be like? And everybody kept saying, oh yeah, it's fine. It's fine. You definitely have enough milk and this is just what it's like, you know, it was a lot of, you know, kind of hand waving and denial. And then after four weeks, I went to a breastfeeding group. I went to the Upper East side. I was in the Bronx at the time and, you know, I watched all the other women breastfeeding. It was very different than what I was experiencing. I mean, they were just, you know, and the babies were huge and the lactation consultant weighed my daughter and it turned out she lost weight and was getting almost nothing from me. And by that point, my milk supply had dropped so precipitously that when I

DR. LINDA DAHL: did start pumping, I was only making about two ounces a day from both sides.

DR. ELLIOT BERLIN, DC: Wow. But they didn't have a diagnosis for you?

DR. LINDA DAHL: Nope. Not only did they not have a diagnosis, I was mostly just met with denial. Oh, you have enough milk, but you don't have enough. I don't have enough milk. We'll give her formula, but you could still breastfeed her because you have enough milk. It was cheerleading, you know, to keep me going, but with no diagnosis or explanation for why.

DR. ELLIOT BERLIN, DC: Clearly you're the kind of person who sort of takes that difficult experience and tries to figure out how to prevent other people from falling to the same difficulties. All right. So I'd love to take another break and we come back, find out more about what you learned and how people can benefit from the work that you've done. We'll be right back. Welcome back to the podcast. We are talking to Dr. Linda Dahl. Okay. You've come a long way because now you've written two different books on breastfeeding. So you must've really gone out of your way to find information

and to help people. What was the journey from where you were to where you are today? Just how you put together all the information that you have.

DR. LINDA DAHL: Um, actually at first, when I first started in practice, I was working for a pediatric ear, nose, and throat group and they would get referrals from lactation consultants for babies that had a hard time breastfeeding and they were diagnosed with something called tongue tie. And I never heard of it. And I just thought, well, I wasn't trained well enough and I'm just out of residency. So I can't let my bosses know that I don't know what anything is. I have to research it and figure it out. And, you know, almost self-conscious, um, started reading about it and treating these babies. And I didn't question what I was doing because the results were so immediate and so incredibly helpful. So when a baby had tongue tie that I can

DR. LINDA DAHL: see and diagnose as an ENT doctor, if I cut it, then they could immediately latch on and breastfeed from their mom. And then all of the symptoms that they had were relieved immediately. And so I got more and more referrals and my bosses were confused about why all these newborns were coming in. And so one of them called me aside and he gave me this whole explanation. Well, this is tongue tie and this is how you fix it. And what you're doing is wrong, which was shocking to me because I'm like, what do you mean it's wrong? You know, it's obviously right. It's working. And that's when I realized I was actually developing something that hadn't existed before and he cautioned me strongly against doing it and told me to stop. And I refused.

DR. LINDA DAHL: I mean, I told him, yeah, whatever. You know, I just kept seeing the babies because it was incredible and it was healing every single time to watch, you know, moms who were going through what I had gone through, you know, to be able to heal that suffering so quickly and so safely for their babies that, you know, there's nothing they could have said that would have made me stop. And it was safe. I mean, I figured out a way how to do it that was safe. And then I would immediately get the baby latched on and help the mom latch the baby on. And then a few years later, my bosses dissolved the practice and I ended up starting my own practice. And then the floodgates kind of opened. I mean, women would come. Moms would come

DR. LINDA DAHL: from Connecticut, Pennsylvania, you know, and it was kind of like this underground breastfeeding ring because the pediatricians would tell them not to come and the lactation consultants would tell them they had to come. And then, you know, they try to hide. You know, then I'd see the babies and I'd always write these consultation letters back to the pediatrician thanking them for sending. They never sent them, but I would thank them anyway. And say now this is what was wrong and this is what I treated. But then there were all these babies, a huge portion of the babies that didn't have traditional tongue tie, but they had a hard time latching on and they had all the same symptoms. And those babies, you know, I differed in my diagnosis

DR. LINDA DAHL: and approach than the lactation consultants because they said lactation consultants started calling those babies posterior tongue tie and lip tie. And I just knew anatomically as an air, nose and throat doctor that those things don't exist as diagnoses. And so it took me another probably seven, eight years to figure out what the problem was. And it was all through trial and error and like measuring the baby's heads and seeing what they had in common, their jaw position, their palate, the way what their gape, if they were able to gape or not, even their wound position. I mean, I

worked with cranial osteopaths, with physical therapists, craniosacral therapists, Chinese doctors. So I worked with a lot of different people with a lot

DR. LINDA DAHL: of different approaches and kind of came up with this unifying theory about why those babies can't latch on. And it turns out that the problem, if babies don't have tongue tie, if they can't nurse, usually the problem is that they can't gape, which is that wide opening. So moms are always told, you know, get the baby to open really wide and then put them onto the breast. And then so many times the moms would say, well, the baby doesn't open their mouth. And when that happens, they're often told, well, shove your breast in there or like flange the baby's mouth. You know, like they're told to mechanically get the baby to open. But what I figured out is that the baby can either gape or they can't. And the gape is an unhinging of the jaw,

DR. LINDA DAHL: which is a relaxed position. And then once they can unhinge the jaw to gape, then they can latch on and do all the breastfeeding things that all the breastfeeding books talk about. But if they can't do that first step of unhinging, then they hinge at the jaw and then slide down to the nipple and then move back and forth on the nipple without forming a seal. And that causes friction. And it also causes all the other issues that so many moms deal with. You know, the baby breaks the seal or they fall off the breast or they fall asleep at the breast or they get a lot of gas or they lose their milk. You know, there's all of the problems, the vast majority of problems that moms and babies suffer from when they can't breastfeed

DR. LINDA DAHL: boils down to that baby's inability to gape. And once I realized that, then I, you know, adapted the procedures I was doing to release the gape. And it was just a miracle how many babies we could help a nurse.

DR. ELLIOT BERLIN, DC: Is it different than the tongue tie?

DR. LINDA DAHL: It's different than the tongue tie because tongue tie is when the tissue underneath the tongue doesn't dissolve. And because the tongue is a muscle, if you don't release that tongue tie as soon as possible, then the tongue can't develop normally as a muscle into adulthood. So it's really important to release that regardless of whether or not the baby's breastfeeding. And you have to release it far enough without cutting into the muscle or burning or lasering anything just with you can do it with a scissor and use your thumb to stretch it just along the tissue planes and then the baby breastfeeds. And it's amazing. But this gape restriction is not tongue tie at all. But it happens when the baby's jaw gets set back a little bit

DR. LINDA DAHL: and the roof of the mouth is high, usually when they're engaged in the pelvic girdle early in the third trimester. So their head is stuck in one position and as they're growing, because they grow mostly during the third trimester in size, that's when they get really big. And if their head is stuck in the pelvic girdle, then the only place the jaw has to go is back. So if the jaw set back, the jaw position actually tethers the movement of the tongue. So in those babies where the jaw set back, the jaw set back is what's limiting the movement of the tongue. The tongue can't lift and it can't pull back. It's not about sticking the tongue forward. It's about lifting and coming back. And the roof of the mouth is so high

DR. LINDA DAHL: that the tongue can't make contact and form a seal. So they can't latch on and form a seal onto the breast and pull milk down.

DR. ELLIOT BERLIN, DC: So does this mean that during pregnancy there are things that one might be able to do to encourage a better jaw mechanics, a better latch once the baby comes out?

DR. LINDA DAHL: Absolutely. And thank you for being the first person who's ever said that. Yeah, absolutely. Most of the time this happens when the baby's head engages in the pelvic girdle early, which everybody loves for the delivery because it makes it not always, but it makes it, you know, if they're engaged deeply enough, it makes it easier for the baby's skull to come through. But if baby is in breech position or if they're head down above the pelvic girdle, you know, the same thing happens if they're stuck in one position. You can actually monitor that with ultrasounds during the pregnancy.

DR. ELLIOT BERLIN, DC: Hmm, that's interesting. I mean, it almost sounds like there's a benefit to the breech, baby.

DR. LINDA DAHL: Possibly. In my practice, which is, I mean, a lot. I mean, I've probably treated twenty three, twenty four thousand babies. But most of them are not breech. Most of them are head down engaged. And surprisingly, most babies are not breech.

DR. ELLIOT BERLIN, DC: Most babies are not breech. That's true.

DR. LINDA DAHL: You know, at the end of pregnancy, there's like three percent breech.

DR. ELLIOT BERLIN, DC: So, yeah, it'd be interesting to see if there's a correlation. OK, so you have these two books, Better Breastfeeding and Clinician's Guide to Breastfeeding, both by you and Linda Doll. What's the difference between the two?

DR. LINDA DAHL: The Clinician's Guide was written for medical professionals and health care professionals and it's research based and really more technical. I mean, parents can read it, but some of it's hard to understand. But Better Breastfeeding is really meant for the lay population. It's more easily readable by everybody.

DR. ELLIOT BERLIN, DC: So Better Breastfeeding and Guide to Breastfeeding, Clinician's Guide to Breastfeeding. When you're talking to parents, are these like sort of troubleshooting? Are these like just different things to look for observationally? Are they tips on success?

DR. LINDA DAHL: Well, Better Breastfeeding is really a comprehensive guide to breastfeeding. So it isn't just about what happens when things go wrong. It's an overview of how the anatomy and physiology is supposed to work so that you can identify when it's not working. And some of the recommendations and explanations I have differ from what's commonly said. And then there's another section on identifying problems and understanding the underlying cause so that you can decide, you know, if you want to do anything about it and what you want to do about it.

DR. ELLIOT BERLIN, DC: Yeah, because like what we've talked about here is almost more mechanical. But I mean, I mentioned sometimes there's just not enough milk production or not enough glandular tissue, things like that that aren't going to be fixed by a little snip of the tongue.

DR. LINDA DAHL: Right. Yeah. And it covers all of that, you know. But I think, you know, moms were led to believe that the vast majority of problems with breastfeeding lie with the mother, that the mother got stressed or lost her milk or it was too painful or whatever. But the truth is the opposite is true. Most of the time, if breastfeeding is not working, it's the mechanics of the baby that causes all those other things. You know, unless a mother has inherent low supply, which actually is less common than you think. It happens then, you know, as long as a mom has enough milk or robust amounts of milk, you know, there are many ways to get breast milk into the baby, whether or not the baby can pull out the milk. But, you know, instead of trying

DR. LINDA DAHL: to pump out the milk and use like a feeder that where you tape it to the nipple, you know, like there's all these things that moms are told to do that aren't going to help the baby breastfeed, but it just kind of helps the baby get breast milk. Yeah. Yeah. You know, there's a way the mechanics are supposed to work in the mom and in the baby, and they have to work together. But the book really breaks down all of those different components. So even as moms, as parents, they can figure out what's going on so they can make choices about the way they want to feed their baby that works best for both of them.

DR. ELLIOT BERLIN, DC: It's really interesting what you're saying about the baby's anatomy, because once in a while we do have babies come into our chiropractic office. I mean, we have babies every day, but once in a while we have one that will only really eat on one side, will only feed on one side. And on the other side, they won't feed, which, sure, there's a lot of different things that can contribute to that. But once in a while, it's literally clear as day how their neck is not aligned well. And so if they're laying on one side, they're just really uncomfortable and they start to fuss and whine. And as soon as you turn to the other side, they feel good. The second we adjust that, it's over. It's one of those few things that we see in the office.

DR. ELLIOT BERLIN, DC: It's just like the magic cure. It's magic, yeah. Coming in with a big problem and leave with it resolved. All right. So you must be working on something else. You sound like you never stop.

DR. LINDA DAHL: No, I don't. I actually I'm working with one of the hospitals in New York to try to develop a breastfeeding center affiliated with the hospital so that the mothers that go through there that give birth in their labor and delivery floor have a consistent message from everybody on the floor. But then also when they're discharged from the hospital, they have a place to go to for breastfeeding. So they don't have to search around for specialists, like who's going to see them. There's nobody to treat these moms. There's nobody to follow up with. So I really want to develop a comprehensive center in conjunction with a hospital because they have so many resources and moms have to go back anyway with the baby. So it would be great

DR. LINDA DAHL: to be able to make breastfeeding one of those automatic things that they get support for.

DR. ELLIOT BERLIN, DC: Fantastic. All right. Well, the time went super quickly because you're a great conversationalist and a wealth of knowledge. I have a feeling that if you'll come back, we'll have you back for more specific topics in the same genre down the road.

DR. LINDA DAHL: Wonderful. I would love to.

DR. ELLIOT BERLIN, DC: Thank you. In the meantime, where can we find you online?

DR. LINDA DAHL: My website is www.drlindadal.com So drlindadal.com.

DR. ELLIOT BERLIN, DC: And Dal's D-H-L.

DR. LINDA DAHL: H-L.

DR. ELLIOT BERLIN, DC: All right. I will visit you online. And for our listeners, thanks for joining us. If you want to find us online for more pregnancy and parenting information, visit informedpregnancy.com.

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