



# Neonatal Feeding Difficulties - Ref244

*with Miranda Clayton*

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## TRANSCRIPT

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**Steven Bruce**

My guest this evening is the wonderful Miranda Clayton, one of the most widely respected voices in the osteopathic obstetrics and paediatrics world. Well, at least in this country, I should say. She's teaching and she examines at the LSO. She has been doing that for several years. So there can't be many people who are better placed to answer any of your questions about all things related to the treatment of babies and their mums. So Miranda, welcome. It's great to have you with us. I'm only sorry that it has to be via video link. How are you? When I spoke to you last year, you were suffering from COVID.

**Miranda Clayton**

Oh, thank you, Steven, thank you so much for having me on. I'm feeling much better. I've got a little bit of COVID brain fog. But apart from that, I'm up and running again, thank you for asking.

**Steven Bruce**

Well, I'm very glad that you're feeling fit to do the show, because I know there's a lot of people eager to hear what you have to say this evening. Miranda, can I set the scene a little bit here? Because, I don't know, I always feel that the treatment of babies is a bit controversial, at least in the conventional medical world. Again, I hate using that term. So, what are the challenges and opportunities for osteopaths and chiropractors who want to treat babies and mums these days?

**Miranda Clayton**

Well, I think that the opportunities very much outweigh the disadvantages. I think the disadvantages are probably more around our continuing lack of good evidence base around our treatments, and also from the fact that, in my opinion, we are a very over regulated profession. So although it's easy for me to get baby patients, etc, because I've been in practice about 25 years, I feel quite sorry for new grads, because they're basically not allowed to advertise that they do anything around treating babies or say that they don't do anything around treating babies. And I have actually had new graduates over the last couple of years who said to me, well, I'd love to treat babies, but I just don't see how I can build a client base given that I can't say what I do. So I sort of appreciate that. But on the good side of this, I think that other health care professionals are increasingly understanding what we as manual therapists do, and how we can kind of fit into the whole picture. And one of the things that I was intending to talk about tonight, was really the treatment of babies with feeding problems. And in a sense, what a growing market this is. So if I can just sort of set the scene a little bit on this, over the last kind of 30, 40 years, I know we work in, I think, you know, you and me and all practitioners, we often work in areas with really not an awful lot of evidence base. But for something like breastfeeding, there is a mountain of evidence base, there's so much of it, there is a landslide of evidence base, proving how good breastfeeding is for babies, for all kinds of reasons that we can go on to discuss if you would like.

**Steven Bruce**

Oh, yeah, I think we'll definitely go on to that, of course, the conventional world or the critics of what we do will say, it's all very well, to say that breastfeeding is good, but there's nothing to say that osteopathy can help with it, or chiropractic can help with it.

**Miranda Clayton**

Well, no, quite. And I think I think this is an ongoing problem. But I also think that, because all these mummies now want to breastfeed, and there's all this kind of information about how good it is in terms of the microbiome and future allergies, and all that kind of thing, that we are increasingly getting lots of parents and because patients vote with their feet, don't they really, they don't come and see you if it doesn't work and nothing happens. So more and more mummies want to breastfeed. Babies themselves are hopeless and don't read any of the evidence base and are no more kind of neurologically mature now than they were 30, 40 years ago. So we've got this kind of mismatch between what parents want to do based on lots of current evidence base, and what babies are actually able to do. And we're talking a sort of multi billion-pound industry here in terms of helping babies with breastfeeding. But actually, it's the majority of babies I see at the moment, are struggling with breastfeeding and it's a massive, great issue. It's something that we can really help with. And I think midwives, lactation specialists, breastfeeding counsellors, paediatricians, GPs, they are, I think, increasingly understanding that, even if they don't quite understand our approaches, I think they're understanding that these things are safe, and that they are generally or quite often effective.

**Steven Bruce**

Can I clarify what you said a minute ago, Miranda, you said that most babies are having difficulty feeding. I take it that you mean most of the babies that come through your door are coming because they're having difficulty feeding. Not most babies generally.

**Miranda Clayton**

No, most generally aren't. But more babies are. And more babies are because I think the culture has moved from bottle feeding, which is really easy for babies through to breastfeeding, which is much more challenging for babies, and always has been. But we also have two particular issues going on here. One is that tongue tie is on the increase, it's not just being more diagnosed, it actually is being on the increase.

**Steven Bruce**

Is there a reason for that? Why would that happen?

**Miranda Clayton**

I think it's actually it's actually genetic. The gene that carries it is, what's it called, I think it's an autosomal dominant gene, I might have got that round the wrong way. But what it means is, if your mommy or your daddy carries that particular gene, as a baby, you will definitely inherit that gene, whether you'll go on then to have a tongue tie, and that will be expressed in the baby as a tongue tie, well, you know, genetics is way beyond me. So I don't know. But actually, in the population, in general, what's happening is that we're getting more tongue ties. And something else that's also happening is that women choose to have babies later. I mean, we don't generally have be our first baby when we're 17, 18. Lots of women are having babies considerably later. Now, what this means is, because there is evidence base out there that if you're over late 30s, early 40s, if you let a baby go beyond term, so longer than it's normal, 39, 40 weeks, there are dangers in doing that. So a lot of pregnant women are very much coerced into having inductions or elective C-sections, possibly before babies are ready to come out. And it's, I think, at the moment, lots of babies are not what I would call, they're not technically premature. However, they're

being born that week, two weeks, three weeks, before they're actually fully cooked. And I think that that is also something which is increasing these breastfeeding problems that I'm sort of seeing generally.

**Steven Bruce**

When people determine what the due date, the fully cooked date, is for a baby, how accurate are they? I know, I ought to know the answer to this. But it seems to me that there's a lot of fudge factor around the actual date of conception.

**Miranda Clayton**

Yeah, well, there can be, and I mean, I can't answer that question I'm afraid. I don't know. I've often wondered. And I often ask parents, do you actually think that the dates were right? And some women, of course say, oh, absolutely. Yes. I know exactly when it happened and whatnot. And other women say, well, I haven't got a clue because my cycle is terribly erratic. And it could have been, you know, so I'm not sure those things are, are actually that accurate. I mean, a lot of it's done, though scans as well. And you know, medical professionals who see 1000s of pregnant women and look at 1000s of scans. So I don't think they're terribly inaccurate. But I do think women are under a lot of pressure, particularly older women, to finish a pregnancy and get the baby out, rather than leave it a little bit longer. And some of the kind of oropharyngeal and primitive reflexes, perhaps and not fully formed, if you're bringing babies out two or three weeks before they would have chosen to come out.

**Steven Bruce**

Even such a short time before they would normally have been due?

**Miranda Clayton**

I think so. It depends what reflex you're talking about. But if you're talking about something like, let's get a slide up here, actually. That's right. So phasic bite reflex. Now this is a primitive reflex. What it means a primitive reflex is that it's a reflex, which you grow out of. So it's a sort of building block onto which other reflexes, more sophisticated reflexes will build in time, but you're born with something called the phasic bite reflex. And that means is that if you press on a baby's bottom of kind of mandible gum, the little jaw will flap up and down. So it will open close, open, close, open close. And this is something which benefits breastfeeding like that. And so it's a sort of like a pattern, that the little baby's jaw's going like that. And that's the phasic bite reflex. Now, the thing with this reflex is, it doesn't emerge until about 38 weeks in utero. It's a very late reflex to emerge. And so I think here that say you were born by elected C-section, because you had an older mummy at 39 weeks, you could argue that possibly this primitive reflex won't be there. And it could be a reason why a baby might really struggle with its breastfeeding.

**Steven Bruce**

Right. Okay, just before we go on Miranda, I did have a question that came in a little while ago, Pipp has asked why tongue ties might reattach after they've been cut. And she'd also like to know whether you think that lip ties are important or not, I don't even know what a lip tie is.

**Miranda Clayton**

Okay, so lip tie is the bit from the top of your lip. So it's like a frenulum under the tongue, but a lip tie is usually sort of from the top lip to the top gum, you can also get buccal ties. So, anywhere in the mouth,

you can actually get little sort of, it's almost like a little tie across, which shouldn't be there. Now, I think that in terms of reattachment, I think it's very important with tongue ties, and it's something that I will spend time doing with parents, that they are taught to rehabilitate babies after they've had a tongue tie operation. So what you want to do is, you want to immediately try and get the baby latched on and feeding so that its tongue will start flapping up and down. And that will sort of stop the reattachment. But some babies, after they've had tongue tie operations that do tech, they either don't respond or they take days to respond, because you've got a whole really complicated neurological circuitry here in terms of the tongue. And I think if the tongue isn't encouraged to move well enough, then they can reattach. Now, what used to happen in the past is, and this sounds rather horrible, but they do a tongue tie and then they would teach the parents to push where the frenulum was under the tongue to stop it reattaching. Babies hated it for a good reason. And also, why would you push a wound, I mean, pushing a wound is not normally the way of actually getting it to heal. So this is not the current advice. But I think that sometimes parents aren't really given enough advice about how to keep the tongue moving. And there are some lovely videos on YouTube about how you play with a baby's mouth, go inside the mouth, stretch inside and, you know, generally sort of encourage the baby to use its tongue. And I think the more that you do that, the less likely they are to reattach. But it's not an exact.

#### **Steven Bruce**

No, okay. We've had a speaker before that, who suggested on this show that perhaps we're a little bit too keen to snip tongue ties. Do you think that's the case?

#### **Miranda Clayton**

Oh, absolutely. But the problem here is, parents love tongue ties. All right, parents, they love them. Because they make sense to them. If your baby can't suck and somebody says yes, there's a piece of string under the tongue and if you snip it, the baby's tongue will be able to flap up and down again. It totally makes sense, doesn't it? You just think, yes, that's what it is. So and because it's like a one-off kind of thing. Because parents have no idea of the complexity that it actually takes for the mouth and tongue and throat and swallowing and you know, everything else, we can go into later. They haven't got a clue. They just think you snipped through something that oughtn't to be there, and it'll work again. Sadly, not always the case at all. So I quite agree with your other guests. I think they are, I'm not sure that over diagnosed, I think the problem is that often babies have tongue ties. But that's not what's giving them a feeding problem. And so it can be very disappointing for parents, so they get them snipped. Nobody's doing anything illegal here. Nobody's pretending they've got tongue ties when they haven't. But parents also are very, very insistent on having, honestly, Steven, 50% of babies I see have had tongue tie operations. Okay. 50% cannot have tongue ties. It's genetically impossible that that many babies have tongue ties.

#### **Steven Bruce**

They must have snipped something.

#### **Miranda Clayton**

But they've snipped something. And they all have the sort of laser sting at the back. I do think it's a whole industry. And you know, it can be jolly expensive. You can have somebody come around to your house and do it for less than 200 quid, you can go to Harley Street, and it can cost you 1500 quid, I could do it.

I wouldn't, I'm not going to, I'm not trained to do it. It doesn't cost 1500 quid you're not I mean, it's a big industry for some not meaning to sound completely sort of cynical here.

**Steven Bruce**

Yeah, and I confess, I had a personal interest in this. I have a grandson, obviously, I look far too young to have a grandchild, but I have a grandson. And he had some feeding difficulties. And the first response was that he had a tongue tie snipped, and I wonder at the time whether that was necessary, but his feeding has improved. So something went right at least.

**Miranda Clayton**

Sure. And I mean, the thing is, at that age, often feeding can change from day to day anyway. So you know, and on some babies, tongue tie snips, they're miraculous, I mean, the baby is just so much better afterwards. But there are downsides to doing tongue tie snips as well. And I'm not sure that's ever, when I ask parents does anybody, you know, we're constantly as osteopaths being told to ask for informed consent. And we're taught to tell patients about all the horrible things that could happen to them if things go wrong. When I've asked parents, has anybody ever explained to you what could happen with a tongue tie? I mean, nothing cataclysmic but that it might not work, and it might make it worse. And when I said to parents, everybody's like, nobody ever said to us that it could make it worse.

**Steven Bruce**

I think we will get comments about the disparity in claims that can be made in what is regarded as a conventional world and what is ours. You said we were overregulated earlier on, I suspect that we aren't any more regulated than doctors or nurses are regulated, it's just that people are more prone to complain about us. Whereas medicine which is provided by the NHS or by established doctors is accepted and is very rarely blamed for things that don't work, unless there's obvious negligence. But anyway, moving along from that, one of our audience today, who I am being told his name is and I know it's a him, is MTBs are better than road bikes, so Robin, good to have you on the show. Thank you for joining us. He says, can you detect a tongue tie in vitro, now I presume he means in utero and I can't, for my own perspective, see why you would bother to detect it in utero? Because you can't do anything about it then.

**Miranda Clayton**

I think in vitro is in the test tube, isn't it?

**Steven Bruce**

Yes, it is.

**Miranda Clayton**

Yeah. What I would say is, I cannot. All right. There is absolutely no way that I would claim to be able to feel that a baby had a tongue tie in utero. But then I am absolutely not that kind of osteopath.

**Steven Bruce**

What would be the point anyway, could you do about it?

**Miranda Clayton**

Well, nothing really, I suppose that as soon as the baby came out, then you could just snip it. I suppose what you could, sorry, I'm being very flippant. Now, what you could do is knowing that there was a tongue tie and also these things can be familial as well. So, you know, babies were sort of both the parents had tongue ties, they are likely to have them as well. And actually, what you could do is, well, you could do some very nice osteopathic, chiropractic, physio, everything else sort of cranio sacral treatment on that baby, to try and actually treat the floor of the mouth and everything that was sort of surrounding areas, rather than wait and see whether it could get higher at breastfeeding, you could treat kind of pretty instantly.

**Steven Bruce**

Once again, you couldn't do that before the baby was born, at which point there was a much easier way to look for a tongue tie.

**Miranda Clayton**

Absolutely. Also, yeah, I mean, we aren't allowed to do anything to babies in utero, anyway, but I have worked with all sorts of people who claim to be able to feel all kinds of things, which are actually out of my palpatory range. But I don't necessarily doubt or I have no idea whether they couldn't feel those things, or not. All I'd say is, I'm just quite structural. And I'm quite honest, I can't feel those things.

**Steven Bruce**

I'm struck by the slight paradox here that the critics of cranio sacral therapy, sacral or occipital therapy would say, well, it just doesn't work. But at the same time, they'll say, well, you mustn't treat babies and their mums in case it does some damage.

**Miranda Clayton**

Well, yes, quite. I mean, this doesn't make sense, does it? I think also, I mean, as a practitioner, Steven, over the years, although I started from a very cranial start point, over the years, I do increasingly less kind of cranio sacral, biodynamic, sort of using the involuntary mechanism, I am getting more and more and more gentle structural with babies, as I've progressed through my career.

**Steven Bruce**

That's interesting, I suspect we'll touch on that in a little while. Can I come up with a couple of questions from the audience to you, before we move on. Mary has asked whether you have an opinion on whether the back to sleep policy has an effect on tongue function, for example, through tensions on the digastric muscles?

**Miranda Clayton**

Yes, I think it does. I'm afraid the back to sleep thing, it's not just about plagiocephaly, but I'd certainly think it affects the whole orofacial kind of region for all sorts of mechanical reasons. And, you know, something has just occurred to me now. I mean, it might be the sort of back to sleep campaign, which I think has been going on since about the mid-80s, hasn't it?



**Steven Bruce**

Wasn't it driven by the sudden infant death's rate, cot deaths?

**Miranda Clayton**

Current policy is that you sleep babies on the backs for the first six months. Now I'm also wondering if maybe the fact that breastfeeding also seems to be slightly more difficult perhaps than it used to be. It may be that all this, it's another thing that's the back sleep campaign, perhaps it also has a knock-on effect on to tongue function. I don't know, it's not something you can research on because I mean, obviously, it'd be thoroughly unethical to do one thing and not do the other, but actually, that's a very interesting question.

**Steven Bruce**

But do you think it's okay to sleep babies on their front?

**Miranda Clayton**

Yes, I do. But I think that you need to be there to look at them. So what I tend to do is with parents, I tend to encourage them to put babies on their front, but only when they're looking at them. So you know, if you're popping a baby down for a snooze for 40 minutes or something, but you're in the room with them, you can watch what they're doing, you're not going to go to sleep yourself, all that kind of thing. I think it's a really good position for babies to be in. But I do think one has to be careful because you know, it's hard for parents, this is very much drummed into them, not putting babies on their fronts and you don't want to go against the information. And also, the thing is, we're all practitioners, we're used to placing patients and babies in positions and using towels and making sure they can breathe and this, that and the other, but you don't quite know what a very tired, sleep deprived parent is going to do. So I'll only say that to a parent if I think that they're reasonably kind of awake.

**Steven Bruce**

Yeah. But it's a curious again, a paradox here, isn't there, as osteopath, chiropractors, we almost certainly advise our adult patients not to sleep on their front. And yet, I know we probably ought to steer clear of advising people to sleep their babies on their front, but we will say it's okay, if you're watching, I'm speaking from my own perspective, as a First Aider. The most dangerous position for an unconscious person, which is, of course, slightly different from sleeping, needs to be on their back, because the tongue can block the airway. Now babies, I don't know where they would fit in that little spectrum between unconscious and sleeping, not quite as in control of their muscles as an adult would be. But again, it seems to me that there are risks from being on your back as well.

**Miranda Clayton**

There are, I think though with babies, I mean, there's a sort of a risk of, it's a bit counterintuitive. But if you're on your back, and your neck is hyper flexed, that is not a good position for a baby's airways. But the thing with putting babies on their front is that all their viscera tend to flop forward. And for a number of reasons, for certain things like colic, reflux stuff and the other, it's a very nice position for their viscera to be in. And I think as an adult lying on your front is often difficult, because, you know, the neck fully rotated is really quite uncomfortable. But babies have a lot of rotation in their necks, and it doesn't seem



to do them much sort of harm to actually be in that position. So the sort of oropharyngeal anatomy round here is slightly different when you're a baby to when you're an adult.

**Steven Bruce**

Yeah, a few more questions for you. Pipp says, what other sorts of things can give rise to feeding difficulties?

**Miranda Clayton**

Well, I think this is a totally complex jigsaw of things, isn't it? Because, what we're talking about, we're not talking about a 100-piece jigsaw here, we're talking about that horrible 10,000 piece jigsaw. So I mean, we've got all the stuff about, you know, maternal environment, and the sort of external environment, the mother, her breasts, her nipples, her milk production, all this kind of thing. And then we've got all sorts of issues within the sort of mother baby dyade itself. But certainly, you know, for babies, I would say the main problems here, one is tongue function. One is mandibular and facial anatomy. We have all sorts of problems that they get around the hyoid bone, the front of the throat. But also, we have to think here about what's going on with the sort of two things, one more globally, that there are very common global patterns that babies have. And actually, the more I treat, the more I'm doing very full body treatments on babies, rather than constantly be looking at the cranial base or the sphenoid, or whatever, I very much moved away from that. Because I think there are two things that we can see in babies with feeding problems. One of them is that often babies have sort of intra uterine compression, so they're shoved in uterus. They're in there for nine months, and they get squished around. I don't think that birth process is such a big deal. But I do think being inside your mama's womb is likely to give you compressions which can have mechanical implications. But the other one really is about neurological immaturity and immaturity through the autonomic nervous system and also through the sort of state regulatory systems. So we're not here talking about a mechanical problem, we're talking about neurological immaturity. So we've mentioned before the phasic bite reflex, and we're saying, that's a reflex. If it isn't there, that give you problems. But there are loads of oropharyngeal reflexes. I mean, if you were to try and learn them all, you'd lose the will to live. You know, they're kind of incredibly complicated, babies don't always have them, for whatever reason, they've not emerged in utero, something's happened, they haven't got them. So there are so many different reasons that babies may have feeding problems, both local, global and neurological. I mean, I can certainly talk more about that. But I don't know where you'd like the conversation to go, Steven?

**Steven Bruce**

Oh, no, no, this is where the audience would benefit from it going. And if they understand that sort of thing, that would be good. There is a question which has come and I'm not sure a name was given to the questioner. But the question was, if a baby comes to you for a checkup, do you have a starting point for just a general checkup in the absence of any known difficulties? And I suppose my follow up is okay, you're doing a check up on a baby, maybe it has got feeding difficulties. Well, how do you determine what is the cause of those difficulties?

**Miranda Clayton**

I think it's a good question that. Over the years, I think that I have realised how important structural examination of a baby actually is. And it's not actually particularly easy to do it. Because they're not

terribly, not very compliant, always. They all come in all bundled up, we can't really see them, you need to get them undressed, which they don't always like, you need to take the nappies off to have a sort of look at what's going on in there. And I think the point with doing a general checkup is, and it's why I think I probably say I've very much moved away from all the sort of cranio sacral way of treating, I do tend to really look at babies globally, and from the feet up and check every joint, you know, what are its feet doing? What are its ankles doing, what are its knees doing. But I do know what a baby's structure should be doing at any particular time. So I've got a norm to compare it with. So I'm generally looking at scanning the whole body, having a look to see whether this baby matches up to the sort of perfect baby for that age range. So if it's a checkup, and in fact, with most babies, if I can't find anything, I can't find anything. I don't really sort of make things up. There are some areas that I think are very important for babies. I mean, I think the diaphragm and the ribcage and the whole cervical lumbar area. I think babies are, by definition, actually quite, breathing is hard for them. It's very difficult for them. It's another source of feeding problems. And I think that's an area that you will find lots of osteopaths and practitioners, making sure that the baby can actually breathe. Because if you can't breathe right from the top of your respiratory tract, sort of down to your diaphragm, actually, you can't do anything. So there's certain main things like that, that I would be looking at. And I think another region that's very important, that osteopaths look at a lot is the craniocervical junction. And certainly, we could maybe have a talk about this as a particular area. And I'm really sorry, I forgotten what the question is.

#### **Steven Bruce**

Well, it started with a general assessment, where do you start? Do you have a routine? And I followed it up with, say if a baby comes in and they do have feeding difficulties, then how do you assess the cause of those feeding difficulties?

#### **Miranda Clayton**

I mean, I think quite a lot of it, I do take a full case history, and we try and work out what's happened so far. I think the main thing is to try and work out, does this sound like it's a problem with the baby? Or does this quite frankly sound like it's a problem, sort of, with the mother or the environment?

#### **Steven Bruce**

What would give that away? How would you make the difference?

#### **Miranda Clayton**

Well, I think that some women who I really suspect have got postnatal depression, or they're really struggling, they found the whole birth process or having a baby very, very difficult and very traumatising. And particularly kind of women who've been all over the place. They've had every lactation specialist in, seen their GP, had the midwife, and everybody's telling them that there aren't any problems, but they absolutely think there are. I mean, it's not that I don't believe them. It's just that I realise there's an awful lot of emotional and possibly traumatic input there. And I think as practitioners, we've all had that experience of having a perfectly healthy baby brought in for us for a birth check. And taking one look at the mother and thinking, oh, my God, do you know what I mean? And thinking, you need treatment, the baby does not. And actually, it's the mother that's suffering. So these would be the kind of things that I'd think, not actually quite sure here that this is a baby problem, if the baby appeared to be very happy, and healthy kind of baby.

**Steven Bruce**

Do the problems largely occur in first time mothers then who really don't know what to expect from their babies?

**Miranda Clayton**

Um, yes, I think so. I think it's much easier the second time. But I also think if you've had, I mean, there's an awful lot of research now on the effect of stress during pregnancy, and how that affects babies. And they're the sort of pituitary axis, their way of dealing with stress. And some babies where there has been a very traumatic pregnancy, they are really difficult babies, they're really unsettled. And there is nothing worse than being with a baby that screams all day. I mean, that's incredibly difficult. Now, when I talk about stress, I'm not talking about kind of middle-class stress that, you know, you may have not got this, that and the other that you want, I don't really mean that. I'm talking about mothers who have awful things happen during the pregnancy, maybe they've miscarried multiple times. You know, it's been an IVF pregnancy and very, very stressful. Their partner has left at eight months, do you know what I mean, people do have horrible things happen to them. And I think the problem with this is, I think it actually affects the babies neurologically. And you're very likely to get one of these really kind of high maintenance babies, rather than getting a sort of lovely placid kind of baby who just eats, goes back to bed, eats, goes back to bed. And all the time, you get these babies that are challenging. So yes, I would agree with you. I think first time parents struggle more. But I guess it's all unique what people are experiencing. Sometimes, they're just knackered because they've already got two small children and another one. And it's just one too many. I think you have to read the family.

**Steven Bruce**

Yeah, I guess it's making me think that there's this huge scope here for treating the mother during pregnancy rather than just afterwards, to try to make sure that the baby is getting the right signals from the mother because she isn't feeling so stressed. And that treatment might not be osteopathy, chiropractic, it might be sort of talking therapies or whatever else it is to try to overcome issues in her mind. But moving on. I think somebody in the audience has learned how to change the name which the system gives him because this one appears to be someone who calls himself Barefoot Rocks, which boggles my mind slightly. I'm not sure how they can be barefoot. But anyway, he says, are there any feeding positions that you would advise people to avoid?

**Miranda Clayton**

No, there really aren't actually, and I try not to go down there. I'll tell you why. The reason is, women get so much advice about feeding positions. And I think the only time I've ever told a woman not to do a feeding position that she was told to do was, someone I saw and she had been told to, let me see if I can demonstrate this with a doll. All right, she'd been told to have the baby like this, lying flat on a bed and dangle her breast and nipple over the baby's mouth, and allow the baby to feed that way. And then she came to see me because she had the most awful back and neck pain. Well, you would, wouldn't you? I mean, what a ridiculous way of trying to kind of feed a baby. But no, I mean, I think babies need to feed in the way that they can feed. The only thing I'd say about that is it's quite interesting the way babies feed, because babies with mechanical problems around the mouth and the neck, they often adopt a completely different breastfeeding posture on one side than the other. So one side, they're fine with a sort of nice little kind of cradle hold, the other side, they can only do it when it's sort of rugby ball. Now,

that might be to do with a mother's breast size, nipple shape, etc. But often, it's actually a clue to the fact that there are mechanical problems going on around the cranial base, the neck, the throat, and the jaw and the front of the thorax itself, but I try not to intervene too much on feeding positions, just because it adds one more piece of complexity to the jigsaw, really.

**Steven Bruce**

Yes. That feeding position that you did describe, was that recommended by a healthcare practitioner or is this some woolly hippy theory that had come out of..?

**Miranda Clayton**

It was by a healthcare practitioner. I was absolutely gobsmacked actually. And I mean far being for me to criticise another healthcare professional, but I really think that that was... Most people are very pressured, occasionally you hear the most peculiar things. I mean, somebody told me the other day that they're weaning their baby about seven months or something. And one of their healthcare practitioner told them to give the baby, if the baby didn't want to eat, to give it chips with salt on it. I mean, a seven-month-old? It's dangerous to give salt, but I mean, you wouldn't be giving chips to a seven-month-old.

**Steven Bruce**

I mean, it's reasonably dangerous to advise feeding any child on chip, as you say.

**Miranda Clayton**

But you know, anyway, one does hear some peculiar things, but not very often.

**Steven Bruce**

Okay. Kim says that her son had a very difficult forceps birth, and as a result had cranial nerve damage. And he never had the sucking reflex. And as a result, she thinks that all babies should get some sort of cranial treatment at birth. What do you think?

**Miranda Clayton**

I agree. And I actually think if they did, Kim, I think that there's certain things like, say you've had forceps birth, and you actually have cranial nerve damage. I mean, it will get better, or it won't. And, you know, our sort of hands-on treatment may be really relieving. But maybe it will take time, maybe it will never 100% come back. But one of the things I do think is that, if all babies had a proper structural checkup by one of us very early on, I don't think we'd be seeing so many tongue tie operations, because I think if we could treat all around the floor of the mouth, and the jaw and the front of the throat, I think a lot of that would sort out a lot of feeding problems early on. And you wouldn't end up having to go down the route of tongue ties. And it's something that really annoys me because I always see babies after they've had tongue ties. And there hasn't been any difference. And I think, well, I do wish you'd come before you'd had it. But this is a culture that, as I said, parents love tongue tie operations. If they don't work, then they tend to kind of fetch up with the cranial osteopath, don't they? That's how it's working.

**Steven Bruce**

I just can't help thinking, is inflicting an awful lot of pain on a baby that can't really tell you what's going on, in some cases for no benefit, and I guess you really answered one of the questions here, which is, do you believe that when a tongue tie is identified in the absence of feeding difficulties, should it be cut?

**Miranda Clayton**

I think no, I don't. I absolutely don't. I don't think there is any evidence at all that children, I mean, if it's good enough, if it's functioning all enough well to breastfeed, I cannot see that that will lead to speech and language problems later on. And if it does, well, okay, you can have a tongue snip later on, but I think best left alone. And I worry a bit about babies, you know, because all the evidence seems to point to the fact that actually, they feel more pain in the first eight weeks of life than later on. When babies are born, they're very poor pain gating. But they also, the vagus nerve, which usually moderates and modulates the way that you as an adult would feel pain. It doesn't happen with babies. So babies actually have the capacity, I think to feel more pain and distress than you do when you get older. So the idea of snipping through the frenulum and certainly poking away at it afterwards. I mean, I don't think there's nerves there that actually crossed the midline. So maybe it's not actually that painful. You know, I don't want to have to do operative procedures on babies unless you have to.

**Steven Bruce**

We've had somebody come back to us about the feeding position that you talked about. Elaine has said that dangle feeding, we have a name for us, dangle feeding is usually recommended for mastitis and blocked ducts. Does that sound reasonable?

**Miranda Clayton**

Yes, thank you very much for that. I didn't realise and maybe that is why my patient was told to do it. I can't remember, it's a long time ago. And maybe for something like mastitis, maybe it perhaps it does help. And perhaps I was being kind of judgmental and scathing there, it just looked really odd to me. Because she'd been feeding like that for quite a while. I mean, presumably, if you're going to feed like that, you're going to feed like that for a fairly sort of short time, until you know, really to sort of drain the breasts and have gravity help and all this kind of thing. But thank you very much for that, because I didn't know about dangle feeding. But certainly, it had given my patient an acute neck problem.

**Steven Bruce**

Yes. And so your patient ought to have known that that's why she was being advised to feed that way and perhaps should have passed that on as well.

**Miranda Clayton**

Yeah, maybe. But I think you know, the thing is sometimes, you know, mums and babies, they're so tired, and they're given so much information. Perhaps she just missed that point of it. Also, maybe she'd only been told to do it for like a couple of days, not three weeks or something, you know, something like that.

**Steven Bruce**

Yes, yeah. Carrie asked whether you find a correlation between very unsettled babies and poor sleeping babies with mums who've required steroid medication during pregnancy.

**Miranda Clayton**

I haven't seen enough to know. But interestingly, I think there might be some research on that. Really sorry, I've read something about that, but I'm afraid the old COVID brain, it's kind of gone. I haven't seen enough women who've been prescribed significant amounts of steroids in pregnancy to make the link. Could you sort of tell us if that's something that you've noticed or read about or know about?

**Steven Bruce**

Carrie, if you can come back to us then that'll be useful.

**Miranda Clayton**

I mean, it might be a nice thing to kind of share if it's something that you know about, do tell us because it's not something I know about.

**Steven Bruce**

What about caesarian babies, I've been asked whether you find there's a particular pattern in caesarian babies.

**Miranda Clayton**

Yes, I mean, I think that the classic pattern with caesarian babies is that they are generally unexpanded. So when I say that, I'm sort of saying, oh, I work on a more structural basis, but actually what I'm saying here is probably more energetic. I feel that the whole of their body and their mechanism, it might be a sort of delayed first breath or whatever, but they feel compressed. And they don't feel like they've kind of inflated like a balloon that they ought to have done at birth, that you take your first breath and it's almost like, everything kicks in, you inflate like a balloon, the whole sort of neurology is kicked on and everything. And I often feel they don't feel like that, they often feel to me, like they've got loads of AP compression, so anterior posterior, either compression, or disparity between the sort of the front and back of the body. So the whole chest often feels, the back and front of the body don't feel like they're sort of moving very well. And you'll often have something like that the front will move, but the back won't move, or vice versa. And they often feel like their heads almost feel like cannon balls, your hands just sit there and then slowly go in and in and in and in. And then you don't seem to feel that nice, energetic kind of flow.

**Steven Bruce**

Earlier on, Miranda, you said that you don't subscribe necessarily to the benefits of the birth process. I don't remember very much from what my cranio sacral teacher told me at college. But I do remember particularly him saying, and many people since, that that whole compression and release of the birth process is very, very important. And that sounds as though you're saying that's what was missing?

**Miranda Clayton**

Yes, I mean, I think that the way I was taught paediatrics was probably that the birth process almost took pride of place, you know, the birth process was incredibly important. And probably a lot of people would disagree with the fact that I personally think that intra uterine compression is more important. And that also, I mean, say around where I work, and where I live, caesarian section is running at about 40%. So about 40% of babies that never go through the birth process, because they're born by emergency or elective caesarean section. And I think babies are built to be born. So the ones that are born through



vaginal births, I think they have all sorts of structural things that make it, you know, the birth is reasonably quick. Being in utero for nine months takes a lot longer. So I'm not maybe quite so convinced that there will always be problems around the cranium, or that the sphenobasilar symphysis might be, there may be a sort of somatic dysfunction around the sphenobasilar symphysis. Or, you know, the bones of the head are made to overlap. And then hopefully, they will decompress afterwards. They don't always, but usually they do. So I know that lots of people really, really believe in the sort of the cranio sacral mechanism, the head as being the thing that they look at first, really concentrate on, they've probably been taught that. I just, as I said earlier on, I think I treat a lot more globally now than I used to and I sort of move away from that a little bit. But you know, some people might completely disagree with me.

### **Steven Bruce**

I've been sent the completely outrageous observation from Claire who says that some of the viewers are speechless that I remember anything from my cranial lectures at college. I think it's dreadful, a slur on my character. Probably well justified. That's not the point. Carrie says that she totally agrees that many tongue tie divisions are unnecessary and osteopathic treatment could relieve much of the problem. However, I've seen a few toddlers she says where a tongue tie wasn't diagnosed until they had a very poor speech. And then dealing with the tongue tie was more complicated. Any thoughts on parameters of when to snip to prevent later complications or just wait and see?

### **Miranda Clayton**

I mean, that's really, really difficult. I mean, I think, you know, I don't consider myself enough of a tongue tie expert. I mean, I guess if you were a tongue tie assessor, and you saw a tongue tie, which was really significant, but for whatever reason that baby was, you see, sometimes, and there are significant tongue ties, they're not causing a feeding problem, because the baby's bottle feeding, and so they don't get picked up on till later on. Whereas if that baby had been breastfed, maybe it would have been picked up on because it would have found it very difficult to breastfeed. But there also may be a scenario that, you know, you have a baby who manages to find its way around breastfeeding, but it does have a significant tongue tie. So I think I'm sort of making the assumption that if babies can breastfeed, the tongue tie can't be that significant. But I don't think that would necessarily go for a baby is bottle fed. And it is difficult. I mean, there aren't any sort of set parameters around that. And I think you'd have to have a very good and also very honest tongue tie assessor, who would actually say, no, there's no problems here. And the tongue tie is just moderate. So we'll leave it, or maybe no problems here, but actually, that is significant tongue tie and it sort of needs doing.

### **Steven Bruce**

This is possibly a stupid question on my part. But why does a tongue tie operation become more complicated in an older child? I would have thought with a larger mouth, it will be easier.

### **Miranda Clayton**

Yes. I don't know. Actually, that's a really good question, Steven. I can't really answer. I know that they're more complicated. Perhaps it's because of, you know, children are then sort of, I mean, I suppose the problems with toddlers are, that they do endlessly stick their fingers and dirty things in their mouth, which babies are not able to do. I mean, when babies are having tongue tie snips, they're not really up to anything else. I mean, all they've got in the gap coming in the mouth is milk. So the possibility of infection



is obviously going to be less, whereas you can imagine with a toddler or an older child, they're going to constantly be fiddling around there, shoving horrible things in and also that, I mean, neurologically as well, the tongue is very complicated, muscle wise, neurologically wise. And it's also linked up to all sorts of neurological central pattern generators. Now, I guess the point is that if you have snips in early life, then yes, a baby has to relearn to use its tongue. But if you already learned to suck, and you've learned to eat, and chew, and you've started to kind of speak, the neurological connections are way, way, way more complicated. And so if you cut through the tongue at that point, you cut through the frenulum, it may well be there's an awful lot more retraining, and you may get a lot of sort of behavioural regression going on there while the tongue is learning to be a tongue again. Also, the way that the tongue moves shapes the oral cavity, so I guess as well, if you do have a bad tongue tie, and it isn't kind of fixed, then it could be the kind of thing that might give a child a developing high arch palate and maybe they would be mouth breathing, not nasal breathing. So I sound here like I'm completely contradicting what I said before, I think probably more what I meant before was trivial, or thick tongue ties that don't look too bad and there's no feeding difficulties, no, I don't think they should be snipped. But as your viewer mentioned, sometimes things are more complicated than that.

### **Steven Bruce**

A few minutes ago, you mentioned the tongue's role in central pattern generation. Can you elaborate a bit on that, what you meant by that?

### **Miranda Clayton**

Okay, so obviously you have all sorts of bits of the central nervous system and peripheral nervous system. And to what extent these things are working when babies are born, they're just working, they just about work. What central pattern generators are, they're parts of the nervous system that are able to generate patterns. So like for instance, with breathing, you don't have to think and take every breath. Neurologically, there are pattern generators, whereby unless something else intervenes, this pattern of breathing in and out will keep happening. And some of the oropharyngeal reflexes and things to do with sucking, swallowing, breathing, all these things, they need neurological central pattern generators to help this pattern. So when a baby starts sucking, it doesn't just suck once, and then have to think and suck again and suck again, once the thing has actually started to suck, it will have a central pattern generator that will keep that neurological circuitry going and going and going. Now, we don't really know when babies, particularly like premature babies and things, maybe some of those central pattern generators, they're not even ready yet, they're not even working yet. And that's why a lot of premie babies, they can't feed or they have very early nasogastric feeding, they never really can get the hang of breastfeeding. There's a fairly short window of opportunity there. But that's basically what in a very layperson's terms, what a central pattern generator is.

### **Steven Bruce**

Interesting, we've had some feedback about the problems with older children and tongue ties that have just come in. Several people, I imagine, at least some have, told us that tongue tie snip is more traumatic and requires analgesia in an older child, but none is required with a baby. I'm just wondering how people know that it's not traumatic in a baby, I'd thought it was extremely traumatic. They're just not able to tell us quite as clearly as an older child would. But I accept that that might be the case.

**Miranda Clayton**

Yes, I think the fact is that it's supposed to be that, because they're cutting sort of in the midline, and certainly with anterior tongue ties, they're just cutting through the frenulum, that there isn't really supposed to be much innervation there. So it shouldn't hurt that much. However, the posterior tongue ties and when you're actually cutting through little bits of muscle and things, I would imagine that's pretty painful. I can't see how it wouldn't be. You're right, though, maybe but also, I suppose babies just forget, whereas when you're an older child, you can register pain.

**Steven Bruce**

Carrie has come back in with a follow up on the steroid thing. She says she saw three or four babies in a short period of time, and they all seemed to present with a very similar pattern of symptoms or are unsettled poor sleepers. And all had mums who've been on significant doses of steroids during their pregnancy for various reasons. She noticed the similarities at the time, but it was only a few so wondering if anyone else has seen the pattern. So it's not the basis of a research paper that she's thought of this from.

**Miranda Clayton**

And it's come back to me now, there is some research on steroid use in pregnancy and the effects on the adrenal axis. So your stress recognitions later on in life, and I can't remember the study, but thanks very much, because I remember that now. And they had looked at women who had taken steroids for all sorts of reasons and did seem to think that it gave children, they found it harder to deal with stress and it seemed to be having some problem with this pituitary adrenal axis, they thought maybe it had some effects on it. In the same way that chronic pain in babies and small children can really affect the adrenal axis. So if that's something that you notice Carrie, no, I don't think that's a sort of just a random thing. I think that there is a little bit of research on that.

**Steven Bruce**

Okay, A couple of questions to take us away from the topic of tongue ties, Miranda. Emma has asked what you would look at for constipation in a four-month-old, predominantly breastfed baby.

**Miranda Clayton**

Okay, well, I'm great with constipation. In fact, I do quite like home visits. And I used to go to one home visit and they call me the poo doctor there, because apparently just sort of...

**Steven Bruce**

It's better than being being called a shit doctor, isn't it?

**Miranda Clayton**

Immediately I looked at the baby and it shit itself. Just one look at me and they just go, you know. So there's something but that's obviously very biodynamic, because I haven't even kind of touched them yet. Are you talking about true constipation? Or are you talking about infant dyschezia? I mean, there's a big difference here. You know, true constipation is unusual for babies. So true constipation is defined by a hard stool. And it's often to do with allergies or intolerances, all kinds of gut biome problems. Dyschezia is that thing that babies do between when they're born and six months of looking like, they're doing a poo

and it looks like they are being tortured by devils. You know, I mean, there's groaning and farting and writhing around. But what comes out is nice and soft. And you think, why was that such an effort? You know, what could have been so difficult about doing that? And there's so many babies who do this, have this behaviour that they now call it infant dyschezia. And it's sort of healthy babies who struggle to poo for no particular kind of known reason. But true constipation, you really need to keep your eye on it. I mean, I don't know if you can remember, cast yourself back to pathology days. And there are certain things like, do you remember Hirschsprung disease where you have sort of aganglionic segments in the colon, whereby the bits of the colon don't actually work properly, so they're not really pushing, they're not pushing the faecal matter through. And you've also got a lot of reflexes going on, when babies start to feed, there's a sort of, I think it's called the aural colic reflex, or something like that, that as soon as they feed, their colon starts to push faecal material towards the rectum. And so, sometimes that then gives them pain and people think, oh, they've got a feeding problem. But actually, they haven't. It's just that this reflex has been started off and then of course, the baby feels it kind of, you know, everything chugging on down the colon to eventually evacuate. And that makes it cry for other sorts of reasons. So I think it depends which thing you're talking about. I think like everybody else, I would look at sort of pelvic, and I've had lots of success often looking at hip joints, and psoas, it's the sort of the sigmoid colon, it's sort of favourite areas of mine, that often I find that if you sort of unwind the baby from the hip joints, you manage to kind of perhaps fascially, myofascially unwind the whole of the pelvis. And this seems to have a very good effect on the viscera itself. So just something I want to have a look at it because we're talking about kind of full body, if you're talking about things like lower gut problems, whatever they might be. This picture of this little baby. This is an incredibly common pattern that babies lie in, whether it's to do with you try and lie or the way they've been born or whatever, but they often lie like this with the head and neck rotated round to the right and a bit extended, and the trunk is side bend to the left, the pelvis is sort of hitched up on the left and rotated to the left with the left sacroiliac joint dysfunction. And if you don't have a look at that, you can see that there is a whole body torsion going on there, from the top of the body, right through to the baby's bottom, you know, and the bottom bit of the body. And it's such a common pattern, there's obviously some really common compensatory pattern. And eventually, there's no adult that looks like that. So you know, eventually, we obviously, we work these kinds of patterns out, but in early life, and sometimes you see exactly the reverse. So it's like flopped the other way, the head is looking to the left, the pelvis is going to the right. But I often with babies start with really simple things and look at an overall kind of posture and particularly with things like pooing problems in dyschezia, there's two things I want to know, one of them is if there's a static posture, like this. And the second thing is, is the baby able to rotate around the mid line axis, through its spine, and through its pelvis, and through its hips, because those functional movements are really, really important to every movement we do in life. But I think they're very important for one's digestive function. And if babies are in this funny old position they get in, or their pelvis is completely rotated around to the left, and when you try and rotate it around to the right, they can do it. But they're immediately flop back to the left again, then I would spend a lot of time in the treatment and it seems a very simple thing, and it is very simple, but just rotating them around the other way, do nice exercises, moving their hips, unwinding their hips, and that often has a really, really good effect on the whole of the pelvic bowl, without having to go into any very tissue or neurologically specific kind of diagnosis, which I think is quite challenging to do with babies. I know people do it, they come up with, oh, you know, it's the right posterior digastric is not doing da, da, da. I personally think it's quite difficult to make these kinds of diagnoses with babies, they're so mobile, they move around all the time, you don't know what the underlying neurology is doing. So I think I tend to assess and treat

in chunks and groups and actually treat quite globally and quite simply first, and then move on to specifics a little bit later on, or if the larger global things haven't worked so well. Sorry, I've lost track of the question, I hope I've answered the question.

### **Steven Bruce**

It was fascinating. And I was intrigued that you say that that pattern that you showed, the right rotated head and the left side bent trunk and so on. You said that was more common than the other side. You said it does happen the other way around.

### **Miranda Clayton**

It does happen the other way around, but it's way way more common that babies look over their right shoulder, and then their pelvis goes the other way. It's not a mechanical problem, Steven, because if you pick the heads up and put them back down, they can do it, it's not a facet joint restriction, it's not like that in babies. It's probably a vestibular problem. It's probably to do with the development of the vestibular system. And there is some really interesting research out there, which is about babies who are breech for long periods of pregnancy. So, you know, they're bottom down through much of the pregnancy. And they stay that way sort of throughout virtually the whole pregnancy. They are much more likely to have vestibular problems which will manifest as sort of balance problems or perhaps slight motor skill problems, proprioceptive problems, that kind of thing, and they think that it's to do with the fact that if when you're, because obviously most babies spend a lot of time in utero moving around and then their head down. And it's different for the vestibular system, which is actually kind of developing here through the ears and through the cerebellum, and these babies have a different experience to ones that are head down throughout the pregnancy. And so this thing about head turn over to the right is probably not a mechanical problem, it's probably just like, either a vestibular sort of slightly hypersensitivity, or just the fact that they've been in utero in a certain position. And so their vestibular system, it feels much more comfortable and natural and normal for them to be, it'll be something to do with the position of all the semicircular canals that are going that way. And when you put them the other way, they cry, and immediately put their head back to the right again, they often have feeding problems as well, because they can feed well on one breast and not on the other because they've got this head turn preference.

### **Steven Bruce**

We had a comment from Xena who says it's a common pattern in adults. I'm assuming she means the side bending, not the sucking on a dummy and wearing a nappy, that's a different business altogether. You said the pattern doesn't continue into adult life I thought.

### **Miranda Clayton**

I mean, you might be right. It's not something that, I suppose in babies, it's so extreme, you know, this kind of head turn and the extension and then everything going the other way. But no, I mean, I mean, maybe you're right, it's certainly more common to get restrictions in the right cranial base. So actually, you may be right, I've probably just been seeing too many babies and pregnant women over the years, and I've lost the plot with sort of ordinary adult patients, I don't know.

**Steven Bruce**

Well, we've probably got a little time just to discuss something else other than tongue ties and constipation. Someone who the system is calling Grateful Beings says, is it just me or is there an increase in reflux cases over recent years? And if so, why and what do we do about it?

**Miranda Clayton**

Um, yes, I think there's a big problem with them. There's a big problem with gastro esophageal reflux at the moment. I think one of the things with babies sleeping on their backs, again, the back to sleep campaign has definitely made reflux worse. Reflux in babies is often easier lying on their front. There's been sort of new research on reflux, and I mean, the way I was taught about reflux was that it was acid reflux. So what was happening is, the babies would swallow the milk and then it would mix with the stomach acid, and they would regurgitate, some of the stomach acid would come up and irritate the oesophagus. But now they realise that, because they have something called, a different test that's been around for a good sort of 10, 20 years, but nobody's ever offered it, but it's called something like impedance monitoring, I think. And they've realised now that a lot of the refluxate that comes up in babies is not acid at all. And actually, the non-acid reflux is in fact more irritating to the oesophagus, or causes more problems in the oesophagus than the acid reflux. Now, the only medications they have for this are either thickeners so that the milk stays in the stomach to start off with, or they'd be things like antacids and acid suppressants. But they don't really work for babies, they're about 50/50 successful and the trouble with antacids is in babies that they give gut dysbiosis after a week of using them, so that you can use antacids on babies you got to 50/50% chance of them working. But in the meantime, they're going to destroy your gut biome. So none of this is good. So there really aren't at the moment any medications, which are good for babies who have reflux. So, parents are very hot self-diagnosing and diagnosing reflux and also silent reflux. So all the symptoms of reflux, but without the regurgitation. And whether there's more reflux, or whether it's just that parents are more concerned about it, and want something done about it. I don't know. I mean, increasingly, they've been directed to medics to not prescribe antacids for babies, because the evidence of whether they work is so poor, but they're still being prescribed like mad.

**Steven Bruce**

Is there a NICE guideline to that effect?

**Miranda Clayton**

Yes, there is. There absolutely is. But I think what it is, is that I feel sorry for GPs, I think most GPs won't prescribe antacids. But people go to see private paediatricians, and honestly, I think parents coerce paediatricians into prescribing antacids and I think babies are prescribed them, because many medics, there really isn't much they can give. And parents want something and are often really quite coercive about it. But yes, the NICE guidelines and international guidelines now actually are saying that unless you've got acid reflux, you know, the actual acid component has been diagnosed, which you can only do by putting a sensor down and doing a proper test for it, which hardly ever happens, you should not be giving antacids, but they're still really shocked about the amount of antacids that are being prescribed for babies, but I do think that's parents being coercive, and also GPs and paediatricians probably just thinking, the baby will grow out of this and just not to worry about it.

**Steven Bruce**

I remember when I was talking to Clive Hade about cranial treatments, cranio sacral treatment on babies, in his case, he was saying there are different types of reflux, but he was saying that in certain cases, manual therapy, cranio sacral therapy can be very effective in overcoming the problem.

**Miranda Clayton**

Oh, absolutely. Because I think the main problem with reflux is that you've got a very weak lower gastroesophageal junction. So where the oesophagus ends and goes into the stomach, the little sphincter around there is very weak, doesn't get stronger until you're about eight weeks to three months, to six months. And in the meantime, the diaphragm and the crus of the diaphragm and the whole diaphragmatic sling bit acts as a kind of a sphincter and it's one of the reasons that osteopaths and other manual therapists are always looking at the diaphragm because we see a lot of reflux. And often, if we can rebalance the diaphragm and get it to function as it should, it will take the strain off the sphincter in the lower oesophagus, and do its job for it until that sphincter gets mature enough to be able to sort of stop refluxing itself. But I would also say, if you're a practitioner, and you treat a lot of reflux, if you do find sometimes that you find it difficult to treat, don't beat yourself up about it. Honestly, dyschezia and constipation are dead easy to treat, reflux, in my opinion, I don't think it's actually that easy to treat. I think it's very challenging.

**Steven Bruce**

Well, I suppose that leads me neatly on to a question from Simon and takes us back to where we started this conversation. Simon says, are we any nearer to being able to advertise our services?

**Miranda Clayton**

No.

**Steven Bruce**

That's a nice simple answer, isn't it? Yeah. I mean, who is doing some research, who is trying to get the evidence together for us to be able to do this, because it seems a shame to me that tongue ties may be carried out unnecessarily. Babies may be given antacids when they don't need them. And yet, innocuous treatment, I am not aware of any serious side effects from cranio sacral therapy with babies, perhaps I'm wrong. But clinically, we've seen it's effective. Surely somebody must be trying to make this known to the conventional world so that they can accept it as an intervention.

**Miranda Clayton**

Well, you would have thought so I mean, I have actually had a long conversation with GOSc about this about three years ago. And I said, well, who's actually responsible, in a sense for doing the research? How are we feeding research through to the Advertising Standards Authority, and all this kind of thing? What do we do about this? And the answer I got was, well, it's the profession as a whole. And I said, well, yes, but who is that? Who is the profession as a whole? Given that we're all self-employed practitioners and I got the answer, well, it's the profession as a whole. And I've kept asking in a different way, didn't get an answer. So I would say that there's probably very little, there's small scale studies being done far more in Europe than in this country. And I think it's always a problem, isn't it? Because, you know, research is expensive and difficult. And unless people are going to make some money out of it, i.e. Big



Pharma or whatever, why would anybody actually put themselves in a position to do it? So I'm not really very confident that we are really building the evidence base. And I think, you know, the evidence base, I mean, because I teach quite a lot, I'm often looking up evidence base, and all the evidence base I look up always is from somewhere else, you know, it's from somewhere else in science. And I will extrapolate that thing that's been found in this particular genetics or this, that and the other to possibly what I do as an osteopath, but there isn't actually an awful lot of research within the profession. So we are in a little bit of a weird position at the moment. But I mean, GOSc obviously are going and will go over the next few years, but I'm not at all sure what the kind of state of play will be when they've gone. And I don't think anybody knows that, whether it will be easier or harder or totally different.

**Steven Bruce**

You make it sound as though we know they will go of course, that's still not decided, and will take several years to come to some sort of resolution and was part of the conversation we had the other night. And although I know that there are some watching who will accuse me of being a GOSc lackey, I know that they do put money into the Encorps. And maybe Encorps could be doing something to promote the evidence behind cranial therapy.

**Miranda Clayton**

Sure, I mean, I might be doing somebody a disservice here. Because it may be that Encorps is totally on to this and all sorts of things are going on within that, but and I'm sorry, what I said about GOSc, you know, my understanding was that they were going but obviously my knowledge of this is out of date. I mean, I realised it wasn't probably for a couple of years. But I thought it that was a done deal. I didn't really realise that.

**Steven Bruce**

It's definitely not a done deal.

**Miranda Clayton**

It's not a done deal. Okay. But I do think it's very, very difficult even for Encorps or whatever, I mean, where does the money come from for this research? If they're going to be valid, they need to be big enough. And for all sorts of ethical and practical reasons, doing anything, on under six-month-olds are really, really difficult, you know, most of the medication that's given to babies, it's just a guesstimate on what to give them because you can't do research. You can't research medication on sort of two-month-olds. I mean, what parents are going to give their babies over to be researched on, it's problematic.

**Steven Bruce**

Miranda, we've come to the end of our time, I'm afraid, but a few things before we go. Carrie says that there's a QTs trial going on, I don't know what QT stands for. But people always find wonderful acronyms for their trials. This is for osteopathic treatment for babies, but it's for a general unsettledness rather than anything specific. And one of the things that somebody sends in, again, I don't know who sent this in. But right somewhere in the middle of the show, you said babies are built to be born and whoever sent this comment in says that's just brilliant. It's such a good thing for all of us to remember. And I was struck too by the fact that you said that sometimes a baby comes in and you think it's the mother that needs the treatment. It reminded me of when Claire took our dog to be trained and the trainer realised it was Claire



that needed training. And I remember thinking good luck with that. I've been trying it for 20 years. It hasn't worked out very well for me so far.

**Miranda Clayton**

Yeah, but I bet she's jolly good at training you, isn't she?

**Steven Bruce**

That's what she likes to think. Yes. Miranda, thank you. Thank you so much. Thank you so much for your time. It's been very kind of you to join us. I'm glad to hear that the COVID has got better.

**Miranda Clayton**

Thank you so much, Steven. It was a pleasure.