Lactation & Breastfeeding

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EDITORIAL

Dear members, dear colleagues,

Winter time already lies behind us. The crocuses are popping out of their holes. King Winter is hurrying back to his snow castle, spring is coming soon! The ELACTA Board has started this year in beautiful Finnish Lapland to gain ideas for the next period of time. We personally welcomed the chairwoman of our latest member association VAMY, Minna Rantanen. We are very grateful that a lot of countries are joining ELACTA and we are thus able to continue to strive for the recognition of the IBCLC profession!
The topic of this issue of Lactation and Breastfeeding is the mental disbalance which can occur during the breastfeeding period. The article of Professor Krüger focusses on the pharmaceuticals used during lactation. Dr Grigore has contributed an article about stress and its influence on breastfeeding. Apart from that, the influence of postnatal depression on the relationship between mother and child is described by Mrs Kräuter. Further subjects of this issue are tandem feeding and the cessation of breastfeeding of an older infant. In the handout you will find general information about the use of treatments and medicines for breastfeeding mums.
We are looking forward to meeting you all in Rotterdam, where a well-organized program is awaiting you on the Steamship Rotterdam. Please have a look at our Facebook page and website for the program and the latest news. Because German-speakers within the ELACTA community are numerous, we decided to arrange simultaneous translation in German for the plenary sessions. Additionally, on the pre-conference day (Thursday, 17 May) we have sessions with both English-speaking and German-speaking presenters. Do not hesitate to contact us for any questions you may have.

Have a nice time reading this issue!
Kind regards, on behalf of the ELACTA Board,

Karin Tiktak, IBCLC
President of ELACTA

IMPRINT

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With its articles, Lactation and Breastfeeding wants to go beyond expert information about breastfeeding and also stimulate discussion. Therefore, we welcome your views. Please send Letters to the Editor to the following email address: magazin@elacta.eu

The articles published in Lactation and Breastfeeding do not necessarily reflect the opinions of the editors or of ELACTA. Rather, they are the author's own personal views

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Stress – a Reason for Breastfeeding Problems?

"If breastfeeding did not already exist, someone who invented it today would deserve a dual Nobel Prize in medicine and economics". — Keith Hansen, the World Bank, The Lancet, 2016

Author: Andreea Grigore, Psychologist, MA Cognitive Behavioral Therapies

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In a 2017 jointly initiative called Global Breastfeeding Collective, WHO and UNICEF envisioned a world in which all mothers are given the technical, financial, emotional, and public support needed for them to start breastfeeding within the first hour after their child is born, to breastfeed exclusively for the first six months, and to continue breastfeeding—along with introduction of complementary foods—for two years or more, if both mother and child desire (WHO, 2017).

In order for such an ambitious goal to be achieved authorities, health workers/institutions, communities should join efforts to identify and remove all the obstacles which impede breastfeeding. One of the less considered obstacles of successful breastfeeding is maternal stress.

Stress is part of our lives whether we are talking about everyday hassles or the great life events. Evolutionary wise, stress, or better said our response to stress, our coping mechanisms -fight or flight- is what helped our species survive.

According to Lazarus' transactional model of stress and coping, stress results as an imbalance between demands and resources, so basically one becomes stressed when demands exceed one's resources (the ability to cope and mediate stress). From this perspective is more important our subjective perception of the stressful event than the event itself and that is why the way people appraise and cope with stressors varies enormously (Biggs et al., 2017).

There are situations when stress helps us mobilize our resources and give our best, but there are also situations when stress impairs us to succeed in our actions. When present for a long time, the stress becomes chronic and can lead to physical and/or psychological illness (heart disease, cardiovascular disease, high blood pressure, heart attack, obesity, eating disorders, stroke, psoriasis, gastritis, depression, anxiety, personality disorders). Stress levels can be evaluated by measuring the physiological levels of cortisol – the hormone released as a response to stress.

Stressor is considered to be a serious, unusual event – big life events (divorce, loss of loved one, child birth, dismissal) or relatively minor, daily event (key loss, traffic, tight deadline at work); (American Psychiatric Association, 2000).

But, as seen before, coping with stress is a personal matter due to subjective perception of the stressor's importance. So,

bearing that in mind, let see what could be the stressors that prevent successful breastfeeding in terms of initiation, duration and exclusivity:

Birth

Childbirth is considered to be one of life's significant events and generally a happy one but, for some women delivery can be a traumatic event. The type of delivery (vaginal or cesarean section), the unexpected events that occurred during birth to either mother or baby (emergency cesarean birth, postpartum hemorrhage, preterm birth, infant illness), labor duration or painful labor – are all highly traumatic stressors that could lead to delayed or uninitiated breastfeeding and to delayed or failed lactogenesis II. Stressful labor and delivery, emergency cesarean birth, and psychosocial stress or pain due to childbirth are documented risk factors for delayed lactogenesis (the initiation of plentiful milk secretion). A national survey of 5332 mothers in England at 3 months postpartum revealed that the ones who had forceps-assisted births and unplanned cesareans had also the highest rates of posttraumatic stress symptoms and the most breastfeeding complication (Kendall-Tackett, 2014). Posttraumatic stress disorder (PTSD) is diagnosed when someone meets the criteria established by the Diagnostic and Statistical Manual of Mental Disorders. Most women do not meet all the criteria needed to be diagnosed with PTSD, but they still can exhibit some of these symptoms which undermine their way to motherhood. A variable percentage of women, between 1.5% and 6%, develop a posttraumatic stress disorder following a traumatic birth (Beck & Watson, 2008). One of the basic symptoms of post-traumatic stress is the avoidance of stimuli or triggers related to the original trauma (American Psychiatric Association, 2000) which compels mothers to keep themselves away from their infants, perceived as reminders of the original trauma they endured.

Most of the studies regarding the impact of stress birth on breastfeeding outcomes are quantitative and are based on measuring physiological levels of cortisol and prolactin. The cortisol levels measured in a sample of 136 mothers in Guatemala revealed stress during labor and delivery was a significant risk factor for delayed onset of lactation (Beck & Watson, 2008).

A qualitative research was conducted by Cheryl Tatano Beck, Professor, School of Nursing, University of Connecticut with the help of Trauma and Birth Stress, a charitable trust located in New Zealand, among fifty- two women recruited on line, to find out mothers' breast-feeding experiences after birth trauma. The study concluded that birth trauma can generate two opposite types of breastfeeding outcomes - some of the women in the study abide in their breastfeeding experience (proving oneself as a mother, atonement to the baby, healing mentally) while others curtailed their attempts of breastfeeding (intruding flashbacks, disturbing detachment).

Traumatic birth is a relatively common event and its impact on breastfeeding should not be overlooked. Considering the long and short term importance of breastfeeding for the baby and the multiple health advantages for the mother (including mentally healing through breastfeeding) more coherent strategies are needed to address this category of mothers.

"It takes a village to raise a child" – proverb attributable to African cultures. If you've ever had the opportu- ›

› nity to read the comments mothers post on different Facebook groups, whether it's breastfeeding support groups or any other group dedicated to mothers, you may have often met with comments such as "My baby only wants to be hold all day, to be breastfed every 10-20-30 minutes and I do not have time to do anything, not to cook, nor to clean the house or to go grocery shopping". Or, "my baby wants to be breastfed all night and I am so tired that I no longer have the energy to do domestic chores. How can I make him sleep through the night?"

Any mother knows that taking a shower when having a (breastfed) infant/toddler with whom you are alone all day is almost mission impossible, not to mention eating or brushing your teeth. But then, why do we expect the mother taking care for her baby to also take care of the house? And the mother, who takes care of the mother? Adapting to the new role of mother, the desire to rise to the level of a self-imposed standard, sleep deprivation are stress factors that put pressure on the mother and that could hinder and ultimately undermine breastfeeding. Adding to all of the above the burden of domestic chores is another stress factor which puts additional pressure on the new mother's shoulders. And yet, it is considered that a mother who is staying at home with her baby is literally "sitting" all day, as if she were on leave (after all it is called "maternity leave"); (Hahn-Holbrook J et al. 2013)

Mothers in this situation tend to consider that breastfeeding is what prevents them from performing their tasks related to the house and they begin to look for solutions to accommodate breastfeeding among the rest of the activities and not the other way around.

Urging women to assume the roles of mothers, wives, and housekeepers at the same time and to do it successfully is not only unrealistic but also dangerous. Both the physical and mental health of the mother are essential conditions for the child welfare. Mothers who take care of their infants, need someone to take care of them, especially in the first month after the baby is born when their main focus should be bonding with their infant, meeting his needs, establishing a successful breastfeeding relationship. They need "a village", a support network – spouse, mother, mother in law, sister, cousin, a close friend - to assume the mother's responsibilities, others than the baby.

Although in terms of civil rights women have achieved equality with men, in regard of gender stereotyping is still a long way to go. And that's a way that every one of us should take first at individual level, because it is, first and foremost, a matter of personal believes.

Breastfeeding and returning to work

In 2012, a World Health Assembly (WHA) resolution endorsed "a comprehensive implementation plan on maternal, infant and young child nutrition, which specified six global nutrition targets for 2025", one of these targets being "increase the rate of exclusive breastfeeding in the first six months up to at least 50%". One of the five actions policy makers around the world should prioritize is "empower women to exclusively breastfeed by enacting six-months mandatory paid maternity leave as well as policies that encourage women to breastfeed in the workplace and in public" (WHO & UNICEF, 2012).

Currently, countries around the world offer paid or unpaid maternity leave from zero up to 24 months. WHA identifies among other causes that contribute to low exclusive breastfeeding rates around the world "inadequate maternity and paternity leave legislation and other workplace policies that support a woman's ability to breastfeed when she returns to work".

It is virtually impossible to reach WHA's ambitious goal of increasing exclusive breastfeeding in the first six months by 50% in the absence of maternity leave of at least 6 months.

A study performed among 180 working mothers in Benin City, Nigeria revealed that women find it difficult to handle both domestic and official duties especially when they are still nursing babies. The length of maternal leave among participants varied between 3 months and 45 working days (Alenkhe, 2016).

All interviewed participants claimed that resuming work after the leave was stressful and for 78.9% of them it affected their breastfeeding habits in the following ways and degree: causing nervous breakdown - 20%, being admitted in the hospital, hence stopped breastfeeding - 1.3%, depriving the baby in most crucial times - 18.8% and cessation of exclusive breastfeeding - 41.3% (Alenkhe, 2016).

It is obvious that one cannot speak of exclusive, on demand breastfeeding when mother and child are apart. Any other method of feeding the baby - either with formula or expressed milk offered with a spoon, cup or bottle is not breastfeeding.

Governments around the world should revise their health and social policies in order to protect and support women's efforts to exclusively breastfeed their children for the first six months. There is evidence showing an association between longer maternity leave and longer exclusive breastfeeding duration. Six months of paid maternity leave offers women the possibility to exclusively breastfeed for longer without being forced to choose between earning an income and providing the best nutrition for their infant.

Breastfeeding in public

Public breastfeeding is generally widely accepted around the world even in the absence of legal stipulations. Nevertheless, people reactions are surprising and there are not few the situations when mothers were scolded, expelled or harassed for breastfeeding in public. Many women feel embarrassed or even afraid to breastfeed in public and therefore are facing the choice between nursing their infant on demand or have a social life. One of the options that mothers in this situation take is using expressed milk or formula for the situations when they cannot breastfeed the baby, either they went outside the house together or only the mother. This will have a negative impact on their milk supply, which will downregulate in the absence of baby's demand. Or, some mothers choose to stay in house for fear of heaving to breastfeed their baby in public, this possibly leading to feelings of frustration, loneliness and even depression which could ultimately undermine their efforts of breastfeeding their infant.

To help mothers around the world feeling more comfortable to breastfeed in public more public awareness is needed. Emphasizing the fact that breastfeeding is the biological norm in infant feeding, disseminating the evidence of the many short and long term benefits of breastfeeding for both baby and mother are small steps that could help mothers and the rest of the people understand it's not fashionable to breastfeed in public it's just natural to feed the baby when he is hungry.

In his latest 2016 Breastfeeding Series, Rollins et al. proposes 6 action points needed to be taken at many levels from legal and policy directives to social attitudes and norms, women's work and employment conditions, and health and services in order to protect, promote and support breastfeeding.

But beyond public and health policies or political measures the first thing that each of us can and should do is to acknowledge the value of breastfeeding as "a powerful intervention for health and development that benefits children and women alike" and to change our own perception and attitude towards breastfeeding (The Lancet, 2016).

When it comes to breastfeeding problems, the first reasons we think about are baby's latch, mother's milk supply, if the baby transfers milk and grows by the growth chart but seldom, unless the mother's mental state is clearly altered, we think that maybe beyond all the obvious problems she experienced a traumatic birth or she is tired and lonely or she has difficulties in dealing with her multiple roles. Often mothers' suffering is silent because if their "wound" is not seen, although it bleeds, the others think she is ok. Mothers should be encouraged to talk about their wounds, they need to be heard, seen and accepted with all their problems because the well-being of their children depends on them, and for a mother to do well she needs to be well. Health care providers of all kind should be trained to recognize the specific signs of posttraumatic stress disorders and to investigate more closely the experiences that these women have lived since their childbirth until they met in order to guide them to the right specialist who could help with their problem.

Andreea Grigore
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Postpartum Psychological Disorders and their Effects on the Parent-Child Bond

There are various approaches and opinions. Many therapists also work with postpartum psychological disorders using approaches from behavioral therapy and psychiatrists set great store by psychotropic drugs. However, I am convinced that most psychological disorders are a reaction to the (mother's) biography. Author: Antje Kräuter

Photo: © tiagozr, 123rf

A sad mother shows little closeness to her child.

With my approaches from trauma therapy, which process the stressors lying in childhood, I have longer-term success with my patients. As a breastfeeding counsellor and psychotherapist, I have specialized in the therapy of peripartal problems, with the goal of promoting the mother-child bond as a sound basis for healthy physical as well as psychological development

In the following article, I want to outline the frequency and origins of postpartum psychological disorders, their effects on the mother-child-bond and, finally, present my therapeutic approaches.

What are postpartum psychological disorders?

Postpartum psychological disorders are sub-divided into postpartum depression, baby blues and postpartum psychosis. **Postpartum depression** is a common disorder after a birth. Mothers do not feel up to their new role, don't admit to themselves or others that they simply can't love the baby as they imagined they would. Sleep disturbances, irritability, often endless sadness and despondency, impair their ability to care for the baby and, particularly, the communication between mother and baby.

Sometimes it is only the so-called **baby blues** that occur. The mood is low and mild anxiety and sadness easily occur. This often vanishes quickly without intervention. **postpartum psychoses** are much more dangerous. About 75% of them occur within the first 14 days. They are characterized by sleep disturbances, rapid mood shifts (states of high spirits alternating with unrealistic anxieties and, sometimes, delusions or acoustic hallucinations), whereby there can be a risk of suicide. Here, a psychiatrist must be brought in or admittance to a psychiatric mother-child-hospital must take place. When direct **anxiety or compulsive disorders** occur, these are more likely in those mothers who were already affected before or during the pregnancy. What holds true for all postpartum disorders is that the mothers are not at fault for this. Many adverse factors in life always come together, which can lead to such a disorder. In all cases, help should be given very quickly because the undisturbed devel-

opment of the baby is at risk. Countless studies (i.e. Bühring, 2010) show "that children of mentally ill parents have a two- to threefold risk of developing a psychological disorder themselves". For this reason, I explicitly reserve a therapeutic option for mothers/fathers of babies and small children for which they scarcely have to wait, despite the generally great influx of patients in psychotherapeutic practices.

The incidence of postpartum disorders

Difficulties for mothers and fathers in the postpartum are widespread. In 2002, Stobel reported on 583 mothers in hospitals in Munich that "42% of the women fulfilled the criteria for baby blues and 12% of the mothers fulfilled the criteria for postpartum depression".

Many studies use the "Edinburgh Postnatal Depression Scale" (EPDS) as a basis for the diagnosis of postpartum depression (see **Box 1**). This can also be used by midwives and breastfeeding counsellors.

According to Ballstream (2005), in Germany, the prevalence of depression between 6 and 8 weeks after birth is 17% when using the self-evaluation of the EPDS. According to Goecke et al (2012), 1.9% to 7.6% of mothers had severe symptoms and 10.1% to 25.5% had milder impairments.

Spremberg (2010) pointed out that most studies give a value between 10 and 15% for the occurrence of postpartum psychological disorders. In O'Hara& McCabe (2013), the prevalence was also 10 to 15%. The latter authors define postpartum depressions as any major or subsyndromal depression present at any time during the first year after delivery

Therefore, in the first year of life, one must at least pay attention to mothers, whereby breastfeeding mothers are less often affected compared to non-breastfeeding mothers. As Kathleen Kendall-Tackett shows (2016), breastfeeding reduces the risk of depression, moderates anger and irritability and even decreases the negative effects of earlier sexual abuse. However, with weaning in the first half year and a relevant life history, which I will discuss later, depression can sometimes set in immediately.

If a breastfeeding counsellor recognizes postpartum depression, then she can refer the mother to a psychotherapist (ideally with a trauma therapy approach, inner

GENERAL SCREENING QUESTIONS:

I have felt like this over the last week:

I was able to laugh and see life from the bright side

Just as frequently as before	0
Not quite as frequently as before	1
Rather less frequently than before	2
Not at all	3

There was a lot that I was happy about

Just as frequently as before	0
Not quite as frequently as before	1
Rather less frequently than before	2
Almost nothing	3

I was anxious and worried unnecessarily

No, never	0
Very rarely	1
Yes, sometimes	2
Yes, very frequently	3

I was so unhappy that I had to cry:

No, never	0
Only sometimes	1
Yes, relatively frequently	2
Yes, very frequently	3

Each question receives 0–3 points, which leads to a value between 0-30 in the entire test: If
10–12: Moderate depression
≥13: Serious depression

http://www.mutter-kind-behandlung.de/downloads/fragebogen_EPDS.pdf

Box 1: Excerpts from the EDPS scale to measure postpartum depression

child work and EMDR (explanation further down). One can also find out which trauma therapists are active nearby through the Association of Statutory Health Insurance Physicians in the regions.

Parent-Child attachment disorders with post-partum depressions

Postpartum depressions very often result in attachment disorders of the mother to the baby and, therefore, difficulties for the development of a secure attachment of the baby to the mother. In retrospect, many mothers regret their pregnancy, envy the attention that the baby receives from his grandmother, for instance, secretly react to him with hostility, and see the baby as a competitor, also perhaps in her partnership. They must flee or "give the baby back". This applies not only for mothers but also, in particular, for some new fathers, who perceive themselves as superfluous and feel excluded and unloved due to the baby's frequent breastfeeding.

A large study, directed by Jan Nicholson from the Parenting Research Centre in Melbourne, Australia (2012), showed how frequently fathers are also affected by postpartum depressions. It was amazing that, among the 5000 new mothers and 3471 fathers, not only did 9.4% of the mothers suffer from psychological problems after birth, but 9.7% of the fathers even reported "states of anxiety and many worries and feelings that they couldn't manage it". Often the fathers too "could no longer see the end of the tunnel." Even the researchers were astonished that the "symptoms in the fathers were very similar to the postpartum depression of new mothers". In the evaluation, the rate of those fathers who described such problems was "40 percent higher than among men in general."

The parents affected do not have the hoped-for motherly feelings. They feel helpless to be able to give comfort. If the crying does not stop, they fall into a vicious circle of anxiety and anger. Many interpret their baby's signals incorrectly. Vigorous crying is actually expressing the baby's desperation, but is construed by many parents as anger and aggression.

Thus, depressed parents often feel better when the baby is not there and prefer to move away – the father goes to work, the mother gives the baby to the grandmother to take care of. This must be seen as an attempt to flee from the situation of being a parent.

How breastfeeding counsellors can recognize bonding problems

From the side of the mothers and fathers, we must take a look at whether they are already successfully "attached" to their infant (bonding). Since they themselves have often experienced an insecure attachment pattern, it may possibly be that their **intuitive parental behavior** is not yet completely developed. In this connection, breastfeeding counsellors can review Ainsworth's (1977) four criteria for sensitivity, which are anchored in the research and in practice:

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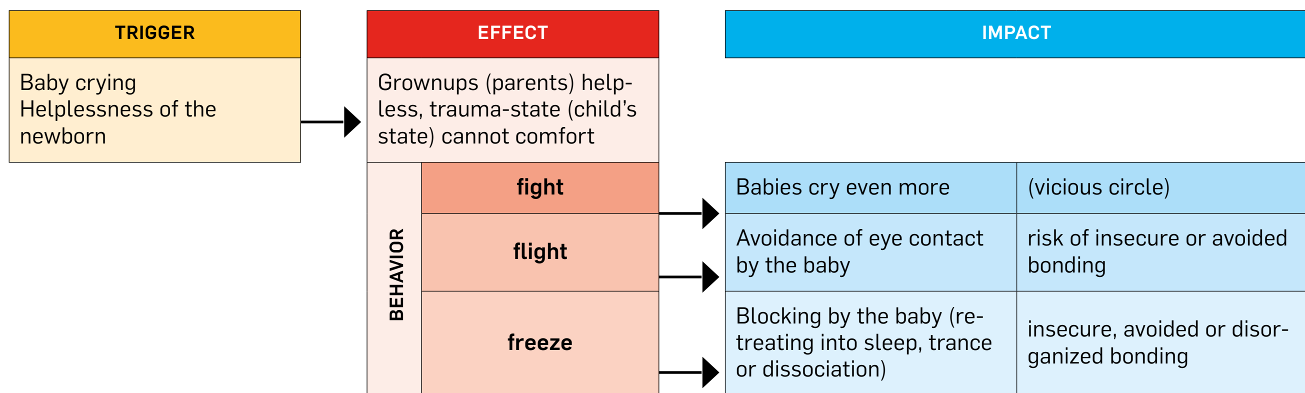

Box 2: Course of postpartum disorders in parents and babies

1. Do the parents recognize the baby's signals?
2. Do they interpret them correctly?
3. Do they respond to them promptly?
4. Do they respond appropriately to them?

Here are some examples of baby signals that must be recognized, which, unfortunately, are often unknown in the psychological research and are scarcely heeded:

- The need for body contact, i.e., in order to be upright and, in this way, burp and digest better and be able to see the world from the same perspective as the grownups (i.e. in a baby carrier); Furthermore, babies need to be warmed on their bellies, because they have a thick layer of fat on the back, but a thin layer of abdominal fat.
- The breast-seeking-reflex (the baby turns his head towards the breast, which looks as if he wants to hide there – in reality, he wants to attach to it).
- An "Eh"- sound from the baby is a sign that he wants to burp
- The tired cry with tones which resemble yawning (Ouh)

Moreover, the communication with and the handling of the baby by his parents can be observed. Parents who do not avoid closeness with the baby frequently bend over the child automatically when diapering him and assume the optimal distance of 25 cm, at which babies can see clearly. They use baby talk for communication. Parents with psychopathological symptoms lack the tranquillity and serenity to engage with the sounds of the baby and to answer them – in the truest sense of the word. The so-called "nurse-speak" involves the imitation of sounds and mimicry and should be melodic. Also, when the parents comfort (their baby) it would be a good sign, if they were to adopt the baby's pitch, often deeper and humming, when trying to calm him and then gradually go higher in pitch and, thereby, announce a happy ending, i.e. the beginning of a breastfeed.

Breastfeeding counsellors can also pay attention to the eye contact between mother/father and child. Is there such contact or has the baby already learned to avoid it in order not to be disappointed again?

In this connection, one can also observe how the parents put the baby on their laps. While among peoples close to nature, the baby mostly sits sideways on the lap und the baby can still see the mother's face for reassurance, in our culture, with an unusually high proportion of insecure and bonding-averse people, placing the baby with his back to the parents and even carrying him this way is widespread!

Postpartum disorders are mostly rooted in traumas or stresses in one's own early childhood

Selma Fraiberg (2011) describes the term "Ghosts in the Nursery", which is connected with the development of insecure attachments and imprints of negative stressors and traumas. The American psychoanalyst reports on how mothers speak in therapy of their "monster baby" who "terrorizes, screams and is never satisfied" and "rules the entire household". She thinks that the mothers are not talking about this baby, but about someone else from her own past whom she feared as a child. She herself was treated dismissively.

In my (trauma) therapy, I often come upon these pictures from their past with my patients. In our brains, the episodic experiences from our first years of life are not exactly consciously saved, however experiences that were connected with strong positive or negative feelings, possibly as visual memories (being able to see the family as well as themselves as a baby!) or as acoustical memories (sounds, formidable voices), also, sometimes, stressful smells (alcohol, odors of something burning) or a disgusting taste. In specific trauma psychotherapies, which, unfortunately, far too few therapists have learned and practiced, one can override these old memories in the brain with certain methods (among them eye movement desensitization reprocessing (EMDR); desensitization and reconditioning via eye movements), which involve the acceptance of the former child, his protection and attention to this baby ("inner child work", imagery re-scripting & reprocessing therapy technique (IRRT) and, thereby, moderating the suffering, which continues right up to the present. Frequently, one can salvage the present from the imagination of the earlier baby in the past. Also, with the aforementioned EMDR technique for processing traumas, one can better remember these stressors and more easily weaken them. The therapist should be well-informed about the behavior and needs of babies and small children so she can reflect these well. Frequently then, healing tears can flow from the person affected. Finally, with EMDR, positive rescue stories are also engraved on the brain.

On this, perhaps a memorable example: A new mother came during my office hours with her first baby, a 5 month old girl. She could not bear the baby's crying

and immediately went out of contact. It hurt her a great deal. Thereby, the baby had no support and continued crying. The crying intensified in a vicious circle. All of this, although the mother breastfed her, carried her in a baby carrier and didn't leave her to sleep alone. She was able to do this well because she had been cared for so well by her own mother.

In a so-called "re-wind", she suddenly saw herself as a two-year old in a crib in the crèche. She clearly saw the bag for her pyjamas hanging there, exactly the same pattern. Then she saw a strange woman and saw her mother going out! She cried and sobbed loudly. After a moment of crying, she was able to see herself, as an adult, going to this crèche, turning to the small child, taking the child out of the crib, saying certain words and taking her with her into the present. Frequently, a rescue narrative about this will be prepared ahead of time, the safe, comfortable place determined and also, sometimes, a rescuer prepared, should the clients not be able to or want to do it themselves. This succeeded and from this moment on, the young woman was able to calm her baby's crying and comfort the baby, as she herself was no longer triggered and did not come into an emotional crisis.

Since 2004, I have worked in this way with new mothers and fathers and experience similar events over and over again. Just a few days ago, a 57 year old, who never wanted a child and lamented her lack of self-worth, "remembered" a terrible scene looking back by focusing on her body. She lay screaming in a crib. It was light and she saw her grandmother and her passive depressive mother (even back then, a postpartum depression). Before that she had felt her arms raised defensively. Her grandmother repeatedly laid the blanket on the baby's head and both (adults) took delight in the baby's screams every time! The strong crying of the client acted as a release and subsequently she carried out the rescue story in her imagination herself. She brought the baby into the present and was able to feel her on her abdomen as she cuddled up. Both feeling scenes were accompanied by different rhythms within the EMDR treatment (here through bilateral acoustic stimulation of the ears with tones from the earphones). The patient did well afterwards.

The baby's crying is reminiscent of (a parent's) earlier helplessness

The new parents are mostly "triggered" by the crying. That means that even the normal whimpering or crying cannot be answered adequately, but is, rather, a trigger for the parents: They hear themselves- somewhat subconsciously – as a baby crying. Thereby, the baby's crying intensifies in a vicious circle. Unfortunately, the notion that a baby's crying is good for the lungs, was widespread. This dates back to the well-known pulmonologist, Johanna Haarer, from the 1930s. She wrote the unfortunate book "The German Mother and her first Child", of which millions of copies were disseminated up through the 1970s in Germany and, also, in other industrialized countries. The societal unconscious deeper meaning was – along with the Nazi ideology of rearing hard men – to rationalize "playing down" the tremendous effort involved in caring for a baby. For, in the course of industrialization and urbanization, there was no longer any extended family, which could support young mothers. Furthermore, the (young) women themselves gradually had to be (at least) partially employed, more and more. The baby became a tyrant who must be resisted. One did not dare "spoil" him! .

This memory of the acoustical storage of the baby cries in the brain of the former baby and today's parent, in the context of one's own mother-baby disorder, leads to many young mothers and fathers falling out of their grown-up state into a helpless child's state when their baby cries: the crying is a "trigger". Such a "helpless baby" is not, however, capable of comforting a baby" **(Box 2)**

But also, the too-early separations from the primary caretakers, particularly care given by strangers and not by loving relatives, are often causes for hidden sadness, which can then be revived, after the birth, especially if this also leads to separations from the newborns.

In many cases, the grandparents also have insecure bonding and psychological impairments, rooted in the war traumas that the great-grandparents experienced. Communication and solicitous and sensitive mothering were (also impaired. All of this can be handed down over generations, epigenetic through genetic transfer (according to Roth 2017)

These old "traumas" (see **Box 3**) must be tackled with appropriate therapies - if possible before the people who were not adequately mothered become parents themselves. Otherwise the risk is great that the relationship with the infant will not function sufficiently well, the parents will experience too much stress, which they often also transfer to the partner and, in the end, believe they must leave him because he is not as she needs him to be. In this way, the partnership is overwhelmed with desires for bonding.

Bonding patterns of the parents

From bonding theory, it can be deduced that the parents also have different bonding patterns and must, therefore, be advised differently (Crittenden 2005).

Since insecure-avoidance bonding in adults leads to their being more likely to follow the rules of authorities than ›

Photo: © AntonioGuillem, iStock

Even concerned parents often wish to have such a good binding relationship.

Psychological traumas which lead to psychological disorders (according to Vogt, R. 2000)

- Pregnancy and birth complications
- Feeding and other difficulties in infancy
- Bonding difficulties with a primary attachment figure
- In-patient hospitalization as a (small) child
- Neglect
- Having to stay alone as a child, being locked up
- Abuse
- Sexual assault
- Emotional stress by shaming or humiliation
- Sadism through sects
- Adverse effects from tightly organized systems of religion
- Accidents in childhood
- Accidents of the attachment figure
- Attachment figures not resilient due to their own psychological disorders/ traumas

Box 3

› their own feelings, it is important here to reflect the baby's needs diplomatically. These parents are seldom sufficiently sensitive. Psycho-education is, nevertheless, useful in order to communicate the new scientific knowledge. The professional journals of the breastfeeding organizations, but also our page of the Initiative Frühe Kindheit (Early Childhood Initiative) (www.fruehe-kindheit.net), serve this purpose.

For the securely bonded parents, in particular, psycho-education is often sufficient. They quickly feel that they can trust their "motherly feelings". Up until then, they were mostly made to feel insecure only through opposing information.

Anxious-ambivalent bonding in childhood leads to insecure-anxious adults, who may still be entangled with their families of origin, even though these influences are frequently counterproductive for their parenthood. They doubt and have too little trust in themselves, but are often very loving, very physical and sensitive towards their children. However, this often goes well beyond their goal since they can transmit their own anxious feelings to the small child. The work with these parents is very productive, but here the parents are encouraged to be more rational and structured. Their anxieties are often unjustified. However, they willingly accept confirmation of their appropriate mothering (i.e. the advantages of carrying (the baby) and the family bed). Thereby, they achieve a great feeling of security and thus, their life with the baby can be significantly easier. Knowledge is power! However, addressing parents' aggressiveness or helplessness, sadness or feelings of overload requires stronger support or a therapy that goes deeper.

If, for instance, the needs of the baby become too much after constant care and attention, if despair threatens, then the counsellor can try to reflect for the mother how exhausting her new life really is. Because the parents would more likely want to flee, feel helpless in the face of the child and don't trust themselves to provide sufficient mothering, it isn't useful when the midwife says: Listen to your mothering feelings! The helplessness comes from the mother's own early childhood when she was left to cry. This can be addressed. Perhaps the mother can readily learn from the model of the counsellor how the baby can best be calmed down. However, with parents with complicated narcissistic personalities, one must be careful since these parents are easily insulted due to the deeply hidden insecurity.

Going on the assumption that the baby can trigger the deficits of the parental home of the parents' early life or that the new parents copy the behavioral patterns of the grandparents towards them (internalized ways of behaving) and react dismissively and irritably, therapeutic measures are necessary so that the parents can move away from the old feelings into today's adult life or develop differently than their forebears.

"Experience can change the mature brain – however, experience during the critical phases of early childhood organizes brain systems"
(Perry et al., 1999).

Dipl. Psych. Antje Kräuter
psychological psychotherapist
parent counselling 0 to 3 years
founder of the Initiative Early Childhood
www.fruehe-kindheit.net
lactation consultant AFS

Initiative Early Childhood

With our Initiative Early Childhood (www.fruehe-kindheit.net) we want to give not only parents, but also professionals, important information which can help us to raise securely bonded offspring.

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Adventures in Tandem Nursing

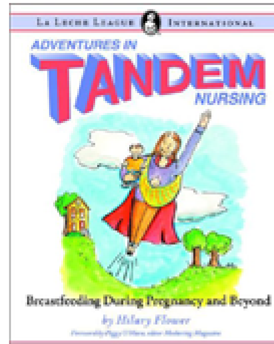
Breastfeeding during Pregnancy and Beyond

Reviewer: Annika Cramer

Adventures in Tandem Nursing: Breastfeeding during Pregnancy and Beyond" by Hilary Flower (2003) is a guidebook for mothers which deals with scientifically substantiated topics around breastfeeding during pregnancy and tandem nursing and, through countless short reports of experiences by those affected, provides support and a better understanding for practice.

The author, herself a tandem nursing mother, was asked by La Leche League to compile a guidebook on a topic which is seldom addressed - if not actually hushed up - in today's Western society because, as we know, the usual duration of breastfeeding does not extend beyond early infancy and is often ended with the beginning of a new pregnancy. So Hilary Flower has divided her book into three parts: Part 1 covers breastfeeding during pregnancy and beyond; Part 2 covers health and nutrition and, finally, Part 3 covers the experiences of the mothers affected.

I have also breastfed during pregnancy and am tandem nursing both daughters, two months and three years old. I could recognize myself in many of the problems, concerns and challenges and, in times of doubt and overload, could, for the most part, restore my confidence simply by reading the short anecdotes about the mothers affected.". For me, personally, it did not make sense to work through the book from the beginning to the end. I could gratefully pick it up on a regular basis for questions that arose or also at particular low points and search for solutions, which I also found – mostly even more than I was expecting. The author illuminates the biological, physiological but also cultural side of breastfeeding, dispels prejudices – which they mostly are – which move women to (too early) weaning, but also addresses – with clear words – the negative feelings, which are involved with this somewhat extreme/more difficult form of breastfeeding: Negative feelings related to breastfeeding the older child during pregnancy and/or after birth. The mere fact of knowing that such feelings are normal is a comfort and helps either to respond to these feelings and wean or, with the aid of the book, to find solutions that make continued breastfeeding possible.



Adventures in Tandem Nursing – Breastfeeding During Pregnancy and Beyond

by Hilary Flower

ISBN 978-0912500973
La Leche League Intl.
(1. July 2003)
From 62,39 € used at Amazon

Annika Cramer
Master of Arts in language, culture, translation (Chinese and English)

EDITOR'S NOTE:
It appears that there is a second edition in the works. See: www.facebook.com/AdventuresInTandemNursing/

Finding the book:
ISBN 978-0912500973
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(1. July 2003)

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elacta
European
Lactation Consultants
Alliance

www.elacta.eu

Medication during Breastfeeding

Photo: © fizkes, iStock

Dear Mother,
When you are sick or have some concerns about your well-being, confidently turn to your physician! Especially when you are caring for a small baby, it is important that you get well quickly (or stay well) and, if possible, have no physical or psychological problems. Timely and appropriate treatment safeguards your health and promotes problem-free continuance of breastfeeding.

Fortunately, for almost every illness, there is medication that is appropriate during breastfeeding. Nevertheless, it can happen that mothers are advised to wean or that the necessary therapy will be refused out of concern for the breastfed baby. Physicians are, as a rule, not breastfeeding specialists so it can happen that the risk of the treatment (through possible passage into the mother's milk) is overestimated, while the trauma of sudden weaning and the risk of "not-breastfeeding" are underestimated. Perhaps the medication of choice during breastfeeding is also not known. Insufficient or false information about the use of medications during breastfeeding on the package insert or in reference books often don't help make the decision by physicians and parents easy.

If there is uncertainty about a medication to be prescribed, the attending physician (and often the parents) can contact one of the many member centers in the European Network of Teratology Information Services (ENTIS) www.entis-org.eu/centers. There are 19 centers in Europe proper plus 3 in Turkey, 3 in Israel, 2 in South America (Brazil and Argentina) and one each in Australia and Japan. If no adequate answer is found, the attending physician may want to contact the Embryotoxicology Advice Center in Berlin (www.embryotox.de) by telephone (many members of staff are fluent English-speakers) to discuss with the specialists the compatibility of a medication and, if necessary, find an alternative that is more compatible with breastfeeding. The attending physician can also get

answers about questions on "off label use", that is, the use of medications which are not approved for an indication during pregnancy or breastfeeding. Due to the limited resources of the Advice Center, questions by parents about treatment with medication during breastfeeding can no longer be answered. However, parents can turn to their midwife or breastfeeding counsellor, who can contact the Embryotoxicology Center for complex cases

Please do not use any medication, herbal preparation or alternative remedy while breastfeeding without discussing it with a physician or another relevant professional and inform your physician that you are breastfeeding before getting a prescription or being examined.

The digestive and detoxifying organs of an infant are still very immature, so that potentially problematic substances could accumulate in the baby's body. On the other hand, there are countless barriers that a medication must overcome before it can become effective in the organism of the breastfed baby. Whether and, in what dosage, a medication that the mother has taken ends up in the infant's circulatory system via the mother's milk is dependent on many factors. Also, the baby's age and the amount of mother's milk taken in (full or partial breastfeeding) play a great role here. The experts at the Embryotoxicology Center can estimate the expected concentration of the medication in the mother's milk and, thereby, ensure a good risk-benefit calculation.

In very rare cases, side effects in the infant can be observed with medications used properly, i.e. "looser" bowel movement consistency when a mother has taken antibiotics, sleepiness with some pain medications or with medications against depression and epilepsy, agitation with medications against allergies.

If no other solution can be found, breastfeeding must be (temporarily) interrupted, i.e., in the case of tests using iodine-containing contrast agents. During this time, the milk production should be maintained with a pump. However, as a "decontamination measure (i.e. after anesthesia), pumping and discarding the milk does not make sense because there is a constant exchange between the milk and blood plasma and, thus, the concentration of medication in the mother's milk declines in parallel to the concentration of medication in the plasma.

If the attending physician recommends weaning, please discuss with an International Board Certified Lactation Consultant (IBCLC) how this process can be carried out gently and how you would feed your baby then. If necessary, the IBCLC can consider, together with you, whether the "benefit-risk-assessment" (risk of medication versus the importance of breastfeeding) has been carried out thoroughly enough and can help you get a second medical opinion.

As side effects, some medications can either stimulate the milk production or hinder it. If you make such an observation, please discuss this with your physician or your lactation consultant.

Andrea Hemmelmayr, IBCLC

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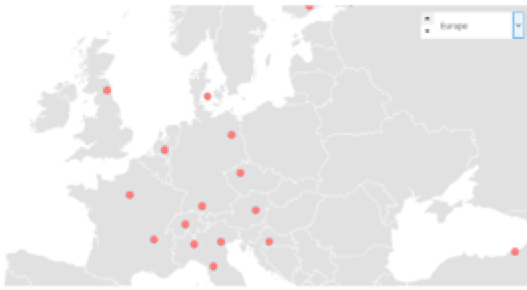
- www.embryotox.de

IBCLC

International Board Certified Lactation Consultants are the only internationally approved breastfeeding and lactation specialists having a medical background.

The decision to breastfeed or not to breastfeed has short- and long-term impact on the health of child and mother. However, breastfeeding sometimes turns out to be difficult and perhaps professional, competent assistance is needed.

Contact your IBCLC



ENTIS-Centres in Europe

ENTIS – European Network of Teratology Information Services

Countless women take medication during pregnancy or breastfeeding. However, for many medications, there is insufficient clinical experience to be able to make a differentiated judgment about the risk of using them during pregnancy or breastfeeding. In such cases, the members of the non-profit organization, the European Network of Teratology Information Services (ENTIS) offer assistance. TIS advise patients and physicians of all specializations, pharmacists and other healthcare professionals on the compatibility and risks of using a medication during pregnancy and breastfeeding. Furthermore, the courses of the pregnancies, in which the centers acted in an advisory capacity, are followed up and documented until after the birth. These data can be evaluated in the framework of multicenter studies to obtain valuable information. This research activity is an important support for achieving one of the primary aims of ENTIS: "to contribute to primary prevention of birth defects and developmental disorders".

www.entis-org.eu
The Website has links to numerous publications on collaborative ENTIS studies of medications in pregnancy. Also available is the English edition of the comprehensive reference book, Drugs during Pregnancy and Lactation: Treatment Options and Risk Assessment, edited by Dr. Christof Schaefer (Berlin Institute for Clinical Teratology and Drug Risk Assessment in Pregnancy), Dr. Paul Peters (University Medical Center in Utrecht) and Dr. Richard Miller (University of Rochester School of Medicine and Dentistry) (USA).

Schaefer, C, Peters, P, Miller, RK, Drugs during Pregnancy and Lactation: Treatment Options and Risk Assessment, Third Edition, Elsevier, Academic Press (2014)
SBN-10: 0124080782ISBN-13: 978-0124080782

Breastfeeding and Mental Health

Excerpts from the Joint Statement from WABA & LLLI in celebration of World Health Day (7 April 2017)[1]:

Linking breastfeeding to Mental Health
After childbirth, approximately 40–80% of new mothers experience mild and transient mood disturbance, while 13–19% develop postpartum depression when symptoms last over 2 weeks. Major symptoms of postpartum depression include anxiety, guilt, hopelessness, irritability, low energy, and loss of concentration. It was recently proposed that breastfeeding can protect mothers from postpartum depression.[2]

Breastfeeding mothers are at lower risk of depression than formula-feeding mothers. Mothers who are depressed benefit from the act of breastfeeding as well. Factors that may be at work in this lowered risk include:

The hormones of lactation
- The hormone oxytocin that is released during breastfeeding has a natural calming effect on the mother, and offers some protection against stress.[2,3]
- The hormone prolactin, responsible for milk production, also seems to protect mothers against depression. One study showed decreased prolactin levels are accurate predictors of depression.[3]
- Both of these hormones act to reduce the body's inflammatory response associated with depression.[3]

Sleep
- Studies have shown that breastfeeding mothers actually get more sleep than mothers who formula-feed or combine the two. They sleep longer and generally feel better.[4,5,6]

SOURCES:

- [1] http://waba.org.my/breastfeeding-and-mental-health/
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10th European Conference of ELACTA

The programme of the 10th European Conference of ELACTA, will cover the main aspects of Breastfeeding.

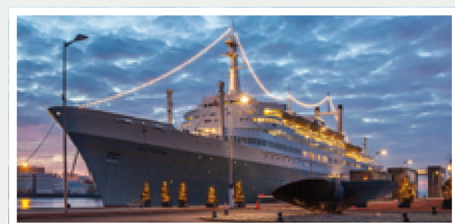
Join our internationals top speakers in Rotterdam!
Register for the Conference and book your hotel now at the unique location, the ocean steamer, SS Rotterdam. Hotel rooms on the ship are limited!

Lactational Programming: recent discoveries on how maternal milk may influence the child's development.

You can read all about our workshops and speakers on our web page.

Accommodation:
Efficient Hotel Partner has been appointed as the official hotel booking agency. The selected hotels are all at walking distance to the congress venue. We have booked rooms in different price categories, both for groups and individuals, at the best possible rates.

You are encouraged to book your room well in advance in order to avoid last minute problems.



The SS Rotterdam can be reached via different options.

› **By car**
When using navigation to drive to the SS Rotterdam, please enter 'Maashavenkade' as your destination. This street will turn into 3e Katendrechtsehoofd.
Parking
The SS Rotterdam car park is located in front of the ship. The rates for parking are €3,- an hour or €15,- for 24 hours. Parking can be paid for in cash and debit card.

› **By public transport**
Bus stop 77 is situated in front of the ship. From Rotterdam Central Station:
1. Take Metro's D or E to Slinge or De Akkers.
2. From metro station Rijnhaven, take bus 77 to SS Rotterdam.
3. From the bus stop SS Rotterdam it is a 5 minute walk to the main entrance of the SS Rotterdam.

› **Shuttle Service**
The SS Rotterdam is well served by public transport. The free shuttle takes you to the metro station if desired Rijnhaven or vica versa. This free shuttle commutes at fixed times.

Accessibility:

› **Air**
Rotterdam is easy accessible from international destinations. Rotterdam the Hague Airport is less than 6 km northwest of Rotterdam. The major hub at Schiphol Airport is only 25 minutes away from the city centre by high speed train.
Benefit from discounted fares on AIR FRANCE and KLM flights when travelling to international events for which AIR FRANCE and KLM are official carriers.

› **Train**
After arrival at the airport an excellent public transport system will be available to bring delegates to Rotterdam. From Rotterdam the Hague Airport bus 33 brings you in 30 minutes to Rotterdam Central Station, or you can take a taxi: in about 20 minutes it brings you to the ssRotterdam. Please buy your e-ticket online in advance and prevent long queues. More information about ordering, prices and planning your journey, see: www.ns.nl

› **Social program:**

› **Welcome reception Town Hall**
On Thursday 17 May 2018, from 17.00 – 18.30 the welcome reception will take place in the Town Hall. The organisers offer transportation. Afterwards it is possible to join a walking City Tour (ticket €7,50).

› **Captains dinner**
You are cordially invited to the Captains dinner. Meet the speakers of the 10th Elacta Conference, in the Grand Ballroom of the Ship.
Tickets can be bought at €60 per person.

› **Partner program**
On Friday 18 May 2018, you can register for the partner program. Your partner and children are welcome for a tour in the Harbour with visit to the famous mills of 'Kinderdijk'. You can register for the partner program for €50 per person.
Please make your reservation when you register online.

Read more on our web page:
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Hartelijk welkom!

zeker over borstvoeding

The Nederlandse Vereniging van Lactatiekundigen NVL (Dutch IBCLC Association) is proud to be hosting the 10th European conference of ELACTA in the beautiful city of Rotterdam, The Netherlands. The NVL celebrates its 25th anniversary this year. We look back on 25 years with lots of progress in our profession.

After the previous conference in Athens, Greece, hosted by Galaxia, we will have quite a challenge to spark your curiosity.

About Rotterdam

The story of the city, the bombardment and reconstruction, and the drive to innovate that locals still use today to shape their city all make Rotterdam a fascinating place to visit. Everything seems possible there, and there is so much left to explore.

Rotterdam is known for its spectacular harbor, but with Hoek van Holland it also has a beautiful beach where you can have great experiences. And ... Rotterdam also is one of the greenest cities in The Netherlands with parks such as the Kralingse Bos, Vroesenpark and The Park at the Euromast.

If you love architecture, Rotterdam is definitely worth a visit. In the city centre, historic buildings and characteristic post-war reconstruction architecture clash cheerfully with the hypermodern skyscrapers built in more recent decades. The Cube Houses, Erasmus Bridge, Rotterdam Central Station and the Markthal: visit them by yourself or book one of the many (guided) city tours.

Rotterdam has a rich cultural life. Renowned museums, art institutions and galleries display the most controversial art, both old and new. Outdoors you also come across the most beautiful artworks and graffiti. See #rotterdamART for inspiration.

Shop until you drop! Whatever your style is and whatever you are looking for, Rotterdam is the place to be. Big department stores and small boutiques, high-end designer stores and small vintage stores. It is all there!

About the programme

The conference committee has been working hard to organize a conference with speakers from all over the world who speak about various subjects about or related to breastfeeding without borders.

Please do not hesitate to contact me at the conference if you have questions about Rotterdam. I work at the Erasmus Medical Center in Rotterdam and am familiar with the city.

We would love to welcome you all aboard the ship of the magnificent SS Rotterdam.

Teddy Roorda
President of Nederlandse Vereniging van Lactatiekundigen

Photos: © nvl

See you in Rotterdam!

Psychotropic Drugs and Breastfeeding

Author: Prof. Dr. Stephanie Krüger, Head Physician, Center for Women's Emotional Health, Vivantes Humboldt Hospital Berlin

Photo: © Deklofenak, iStock

Many women do not want to forego a family of their own despite a psychiatric disorder. Meanwhile, though, the data related to the teratogenic and perinatal risks of psychotropic drugs is so good for most substances that the women can be advised whether the medication that they are taking for their psychiatric disorders is compatible with a pregnancy or which risks they should take into consideration if need be. Safe psychotropic therapy during pregnancy reduces the risk of episodes of illness until the birth and, frequently, also beyond. By contrast, untreated psychiatric disorders represent a high risk for maternal and child safety.

For many women with a psychiatric disorder, the question arising after the birth is whether they can and want to breastfeed. Thereby, it is not only the medication taken but, in particular, the psychiatric disorder for which a routine that is as orderly as possible and a regular night's sleep are the best prerequisites for stability. For many women with psychiatric disorders, breastfeeding means stress. At the same time, they develop a guilty conscience, suggested not least, by their environment, if they decide against breastfeeding their baby. The decision about whether the psychiatric disorder is a contraindication for breastfeeding should be made by the attending physician.

With respect to the safety of psychotropic drugs for breastfeeding, the data for

most substances is sufficiently good to be able to make a reliable statement on their compatibility with breastfeeding. Whether a medication is detectable in the mother's milk, is influenced by many factors, above all, from its distribution volume, its molecular weight, the fat-water-solubility, the relative affinity for plasma and milk proteins, the PH-value of the blood and the milk (to the degree of the ionization of a medication) and the blood flow in the milk. A baby's plasma concentration of 10 % or less is recognized as acceptable and safe (Kronenfeld et al, 2017). In the following, the most frequent psychotropic drugs and their compatibility with breastfeeding will be described.

Antidepressants

The most frequent psychiatric disorders are depression and anxiety disorders. Thus, it is obvious that antidepressants belong to the most frequently prescribed medications for women with mental health problems. There are various substance classes which are used for different indications.

Tricyclic Antidepressants

Here, this involves relatively "old" substances, which are not used so often in modern psychiatry, since they have many side effects.

Fundamentally, these substances are also not recommended during pregnancy due to neonatal adaptation problems (Larsen et al., 2015; McAllister et al., 2017). However, should this group of substances be considered, only amitriptyline is appropriate. Amitriptyline cannot be detected in the plasma of breastfed children and its metabolites are only detected in very limited amounts. Up until now, no symptoms in breastfed babies have been described. (Larsen et al., 2015; McAllister et al., 2017).

Serotonin-Reuptake-Inhibitors (SSRI)

Among the serotonin-reuptake-inhibitors, the older substances, such as fluoxetine and paroxetine, should not be prescribed if the patient intends to breastfeed. Both of them have relatively long half-life times and there is the risk that the substances and their metabolites will accumulate in the baby's body and could have undesirable side effects. In individual cases, symptomatic infants have been described, who have attacks of screaming, which improve by changing the type of feeding. Whether this was seen in connection with fluoxetine or paroxetine, could not be clearly shown (Sie et al., 2012; Pinheiro et al., 2015; Carvalho et al., 2016; McAllister et al., 2017).

If a patient plans to breastfeed her child, substances, such as citalopram, escitalopram and sertraline, are preferable (Sie et al., 2012). Studies show that the concentrations of these medications lie under the detection level of 3 µg per liter.

Dual Antidepressants

Although venlafaxine retard during pregnancy is counted among the very well-researched substances, there have only been somewhat more than 30 mother-child pairs in which the effects of the substance on breastfeeding has been studied. With newborns very different infant serum concentrations were measured, which were mostly under the detection limit for the substance but, in some cases, reached the level of the maternal serum concentration. No undesirable effects were observed in the babies, whereby some of the babies studied were also only partially breastfed. In this respect, a mother who is being treated with venlafaxine retard should only breastfeed if the baby is regularly observed by a pediatrician (Bellantuono et al., 2015; Larsen et al., 2015; Vitale et al., 2016). .

There are published experiences on duloxetine for only about 10 mother-baby pairs. Up until now, there have been no negative effects of the substance on the breastfed baby. However, the number of babies studied is too small to make a definite recommendation. Thus with duloxetine, breastfeeding can only be undertaken with reservations. (Bellantuono et al., 2015; Larsen et al., 2015; Vitale et al., 2016).

Dopamine-Noradrenaline Reuptake-Inhibitor

There have been observations of 20 mother-child pairs with elontril (Wellbutrin). In the plasma of the breastfed babies neither bupropion nor its metabolites were detected (Newton and Hale, 2015; Payne et al., 2017).

Tetracyclic Antidepressants

With mirtazapine, no plasma concentrations have been detected, whereby, this should be qualified since the data with 11 mother-baby pairs is insufficient (Smit et al., 2016)

Other Antidepressants

There is no data on the MAO-Inhibiters, milnacipran, tianeptine and agomelatine. Due to the considerably better-researched alternatives, this substance should be avoided.

Benzodiazepine

Many women need benzodiazepine due to massive tension and anxiety states. Fundamentally, it should be noted that benzodiazepine, which has a longer half-life than, for example, diazepam, should be avoided, since long-term treatment can lead to an accumulation in the baby's body. This can result in sedation, insufficient weight gain, muscle weakness and breathing disorders.

As long as only a one-time administration of a long-acting benzodiazepine is necessary, no interruption of breastfeeding must be undertaken.

Substances with limited to medium half-lives, such as, for instance, lorazepam or alprazolam, are not detectable in the baby's plasma and so are compatible with breastfeeding. (Larsen et al., 2015; Vitale et al., 2016).

Hypnotics

Zopiclone (Zimovane) and Zolpidem (Ambien) are used for sleep disturbances. The data related to compatibility with breastfeeding is insufficient. In the few cases that have been published, there was no accumulation of the substances in ›

the child's plasma so that a cautious recommendation for breastfeeding can be given (Larsen et al., 2015).

Neuroleptics

These are used, on the one hand, against the appearance of psychotic symptoms in the context of a psychiatric disorder and also, on the other hand, for mood stabilization with a bi-polar disorder, for example. Neuroleptics are differentiated into first and second generation.

First Generation Neuroleptics

These substances are fairly well researched. Many studies found a milk-plasma relationship of < 1 without any symptoms in the baby. In this respect, the older neuroleptics (i.e. haloperidol, flupenthixol) are compatible with breastfeeding (Parikh et al., 2014; Pacchiarotti et al., 2016; Hummels et al., 2016).

Second Generation Neuroleptics

Although the substances are used in a broad spectrum of psychiatric disorders, the data is insufficient. Currently, it has been determined that olanzapine, risperidone and quetiapine achieve a milk-plasma-relation of < 1 and that no negative effects on the baby have been observed (Brunner et al., 2013; Aydin et al., 2015; Uguz, 2015; Witworth, 2017). Clozapine is not compatible with breastfeeding since high concentrations are found in mother's milk and in the baby's serum and, with some infants, agranulocytosis and somnolence have been described. Here, there is an absolute contraindication (Witworth, 2017; Mehta and Van Lishout, 2017).

No statement can be made on aripiprazole, asenapine and depot preparations

Mood Stabilizers

Mood stabilizers are used for relapse prophylaxis in affective disorders. Frequently, they are a necessary medication lifelong, so that here, the question of breastfeeding compatibility is particularly important.

There is documentation for nearly 40 mother-baby pairs on lithium. The plasma concentration of breastfed infants varies considerably: on average, 25% of the maternal plasma concentration could be measured. However, in individual cases, up to 60% of the maternal plasma concentration was found in the infant.
Undesirable effects, such as tremors, increasing TSH values, somnolence, increasing creatine values, cyanosis, dehydration and changes in muscle tone, were observed in breastfed infants(Uguz and Sharma, 2016; Pacchiarotii et al., 2016; Uguz and Sharma, 2016).

While earlier, taking lithium was considered an absolute contraindication for breastfeeding, this finding is somewhat qualified. What applies now is an individual decision, depending on the mother's wish to breastfeed and her lithium level. Partial breastfeeding is also an option. Some authors recommend monitoring the lithium level in the infant. However, the risk of breastfeeding with lithium are so high and the need for very close monitoring of the baby so complex that many mothers decide against breastfeeding with this substance (Pacchiarotii et al., 2016; Uguz and Sharma, 2016).

The data on valproic acid is quite comprehensive, since this substance is also used in epileptology, and there is published documentation on nearly 60 mother-child-pairs. The substance is extremely teratogenic and thus should be avoided in the prophylactic phase of psychiatric disorders in women of childbearing age. If this was not possible, the substance appears, by contrast, to be compatible with breastfeeding. With the majority of the breastfed children, no anomalies were found (Veiby et al., 2015; Veronikki et al., 2017).

Lamotrigine is also used as a mood stabilizer in affective disorders, but also in epileptology. Consequently, it has been well-studied with more than 120 mother-child pairs. Most of the breastfed babies do not display any clinical anomalies. Lamotrigine is among the substances for which further child development up to school age has been documented. It showed no negative effect on the cognitive development of children up to 6 years of age (Powell, 2015; Veronikki et al., 2017).

Summary

Women with psychiatric disorders should be able to bring children into the world just as healthy women can. The potential risks of frequently indispensable psychopharmacotherapy must be discussed with the patient.

The uncritical and irrational stopping of these substances can lead to severe relapses.

Meanwhile, for most of the frequently used psychotropic drugs, there is sufficient data available to be able to judge the compatibility with breastfeeding.

What is important is competent advice - free from prejudice - for women with a psychiatric disorder.

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Official Invitation to the General Assembly of the European Lactation Consultants Alliance

Dear members of ELACTA,
You are cordially invited to the General Assembly of ELACTA on

Date: 18 MAY 2018
Time: 17.00-18.30
Place: Steamship Rotterdam, Grand Theatre
Rotterdam, The Netherlands

Agenda
1. Welcome
2. Operational matters
3. Report of Activities
4. Financial report
5. Decharge Board of Directors
6. Voting & transition Board
7. Resolutions
8. Looking forward
9. Questions
10. Closing

Procedural information:
- You can find the ELACTA statutes at www.elacta.eu
- Should you have anything to add to the agenda, please send your additional points to office@elacta.eu by 4 May 2018 at the latest.
- Voting for Board elections can only be performed in writing at the GA or electronically. Please send your e-mail by 8 May 2018 at the latest to office@elacta.eu
- Only IBCLCs can vote. Every IBCLC has one vote.
- The transfer of a vote to another member by means of written proxy is allowed.
- In case a voting about a statement is needed, participants of the GA will vote by show of hands and majority decision. These statements must be part of the agenda.
- Questions to the ELACTA board can be sent prior of the meeting to office@elacta.eu, or can be asked verbally during the GA.

For the list of current board members and co-opting board members please see: www.elacta.eu/our-team

Elacta Board is Looking for New Boardmembers!

- Are you the IBCLC who can do more than support breastfeeding?
- Are you searching for more challenges in a life full of breastfeeding and babies?
- Would you like to level up your supportive profession?
- Do you want to develop your hidden organisational and management skills?
- Love to work together with like-minded personalities from different cultures?
- Would you like to meet 3 times yearly in a different European country with a group of cheerful and ambitious women?
- Do you have some spare time?
- The ability to communicate in English is required.

If so, ELACTA Board would like to meet you!

Please send your email to stefanie.rosin@gmx.de

Photo: © nvl

Breastfeeding a Toddler, Breastfeeding During Pregnancy and Tandem-Nursing

Author: Alexandra Glaß

Photo: © Andrea Hemmelmayr

If a mother breastfeeds her child significantly beyond the first or second birthday, this involves special challenges in counselling, which are different from the indications for counselling with a newborn or an infant. The breastfeeding period may then overlap with the return of the menstrual cycle, with the desire for a new baby, a new pregnancy and, possibly, a second breastfeeding baby as well. Breastfeeding and the counselling situation are quite different when the breastfed child can talk. The mothers are experienced breastfeeding mothers, but nevertheless – or for exactly this reason – they have challenging, not everyday questions and breastfeeding problems, which differ from those in the first six months or breastfeeding in the first year of life. Therefore, some of these aspects will be discussed here.

Breastfeeding an "older" child

In scarcely any area of breastfeeding do such controversial views as those on breastfeeding an "older" child (however "older" is defined now), prevail. Not only in the lay press ("Breastfeeding until the School Bus Comes" or the *Time Magazine* cover, to mention just two), but also among professionals, mothers with children who breastfeed after the first, possibly even the second birthday, are confronted with a lack of understanding. If a child who is older than three is still breastfeeding, the mother often keeps this to herself. Why?

What is it about breastfeeding a child beyond infancy? And how can we support mothers with breastfed children beyond infancy? What are their questions and concerns?

The image of a breastfed child beyond the first birthday is marked by prejudices: the two-year old tugging on the T-shirt; mother's milk that is scarcely different from water…

But is that really so? Let's first take the concept **"long-term breastfeeding"**.

The WHO recommends breastfeeding, along with appropriate complementary foods, up until the second birthday or beyond. According to Dettwyler, the natural weaning age of hominids lies between 2.3 to 6 or 7 years (Stuart-Macadam & Dettwyler, 1995). So that which is ›

› referred to as "long-term breastfeeding" is, rather, the **"normal breastfeeding period".**

Archeological bone and teeth finds also document breastfeeding periods of many years. In the ancient cultures of the world and with the indigenous peoples who still survive today, children were or are breastfed so long. Now, in whatever culture they live, people are also always influenced culturally, even on the duration of breastfeeding. Yet when we look at our closest relatives, the great apes, we see that they breastfeed their children for 5 to 7 years. Evolutionarily seen, that MUST make sense, for only evolutionarily sensible behaviors survive so long.

A mother who weaned at 4 months, would, thus, be practicing **"short-term breastfeeding".**

But do we want to label mothers like this? No, certainly not. But just as we don't want to label someone as a "short-term breastfeeder" or define something as "normal breastfeeding duration", we don't want to label something as "long-term breastfeeding", which, evolutionarily seen, describes a completely unexciting, normal and sensible practice. Sensible for the reason that early weaning has disadvantages.

Photo: © Karl Grabherr

Disadvantages of early weaning

For the mother, the disadvantages of early weaning include, for example, shorter spacing until the next baby as a well-known obstetrical risk, an increased risk of diabetes (Victora et al., 2016), more frequent gynecological malignancies (Kotsopoulos et al., 2012), to mention just a few. This effect is sometimes dose-dependent, i.e. the longer the breastfeeding period, the more significant the effect (Gunderson et al 2018). For the child, these disadvantages, i.e. more frequent infections of the upper airways, including otitis media (Victora et al., 2016) and more hospitalizations due to these infections, higher risks for asthma in childhood, bite abnormalities (Victora et al., 2016), obesity (Gibson et al., 2016; Grube et al., 2015, Wallby 2017), diabetes (The Lancet, 2016), child abuse (Strathearn et al., 2009), to mention only a selection.

When the amount of milk declines, due to the declining frequency of breastfeeding that accompanies the increasing age of the breastfed baby, the amount of lactose decreases but the protein content, primarily the content of immunoglobulins, *increases* (Goldman et al., 1983; Mandel et al., 2005): Despite the decreasing amount of milk, the intake of immunologically effective components remains high. This clearly refutes the old wives' tale that the milk is "only water" or has "no value" anymore.

Breastfeeding counselling beyond infancy

Now, how do we advise and support a mother who breastfeeds for longer than the average in the Western world (in Germany, the average duration of breastfeeding is 7.5 months (Lange et al., 2007))? The questions that these mothers have clearly differ, for the most part, from the questions that are asked about younger breastfed babies. What's the story on the advantages?

Let's take the case of the 2-year old toddler tugging on the t-shirt. Don't other children also have temper tantrums in front of the candy shelf? If a toddler wants the breast when the mother does not want that, this is not a breastfeeding problem, but a completely normal topic, that arises sometime in raising any child. Here, we can

Case Study: Breastfeeding during Pregnancy

C. contacts me with her child, Q., 7 months old. She has become pregnant despite a copper spiral. Q only eats a little. Shortly beforehand, complementary foods with baby led weaning (BLW) was begun. Q will not accept an artificial nipple and breastfeeds 8-12 times in 24 hours. Since the beginning of the pregnancy, C has noticed vasospasms, which do not improve by taking magnesium. She is already noticing a decrease in the amount of milk and less frequent milk ejection reflexes. She is concerned about how this will develop and how Q can get sufficient milk.

Background:
According to WHO, mother's milk provides half or more of the baby's diet in the 2nd half of the baby's first year of life (and also about a third in the 2nd year of life). It cannot be replaced entirely by cow's milk before the first birthday (Netzwerk Gesund ins Leben (Healthy Start – Young Family Network 2016). For Q, the question of how he should get the extra milk feeding arose. During pregnancy, the amount of milk can decrease; how much it decreases is different individually and difficult to predict. For a baby under 12 months who is dependent on mother's milk, this can be a problem.

Approach:
Thus, we talked about C closely observing the baby's sucking and swallowing behavior and growth, conscientiously offering complementary foods (porridge if she wishes, in case she has the impression that the BLW was not sufficient) and drinks. Q could possibly be offered infant formula from a cup. C wants to continue breastfeeding as long as it is comfortable for her. Q still refuses a pacifier. In principle, C would not be opposed if he could meet at least part of his need to suck with a pacifier. But his refusal to take it, is not amenable to change.

encourage the mother, who has also frequently internalized the "breastfeeding on demand scheme", to assert her own needs as a model for the child, to protect his own body and to pay attention to (his) needs and assert himself to get them met. In a society in which every person has the right to thrive, it should be all right to breastfeed a 2 year old child in public. But the mother does not have to breastfeed whenever the child wants to. And when the child learns from this situation that it is all right and important to communicate and defend his own boundaries, then he has acquired this as a value for his whole life. The mother may, at any time, implement changes if she wants to. Breastfeeding is only one aspect in the relational structure between mother and child, particularly if the breastfed child is a year old or older. Neither bonding nor the relationship suffer lastingly if the mother introduces changes on her own. Here, mothers often need confirmation. Ideal for this is a breastfeeding support group for mothers of older breastfed children and an advisor who respects the mothers' breastfeeding wishes.

There are still further questions that mothers with breastfed children who are beyond infancy, deal with: Women often report temporary pain, feeling unwell while breastfeeding, breastfeeding strikes and a reduced amount of milk in the course of their menstrual cycle. The data on these is thin. Theoretical considerations on this blame the changing progesterone levels during the cycle. There are women who scarcely notice changes and others who notice them all the more. This can hardly be changed, yet if the mother understands the cause of this and that it is all right to limit breastfeeding on her own when she needs to, it is mostly well tolerated.

Sexual feelings when breastfeeding

A taboo topic, which is either encountered anonymously on the internet or that women admit privately - at most - to someone under the seal of professional confidentiality, is having sexual feelings when breastfeeding. These are, in no way, to be considered as child abuse. They are an infrequent, but occasional reaction to the stimulation of the nipples, which may occur in relation to the menstrual cycle, but also are observed during pregnancy. Many women are so shocked by this that they want to wean. For others, distraction or interrupting the breastfeed in a concrete situation, may possibly help.

Very often, the question in such contexts is: What is the motivation of the mother to continue breastfeeding? Does she *want* to continue breastfeeding? Why? Perhaps simply because breastfeeding is still so important for the child and weaning seems to be more difficult than everything else? We can help the mother seeking advice to sort through her feelings and work out her motivation from this. When she has clarified what she wants (and that is sometimes more difficult than we assume), then the decision will be considerably easier.

Breastfeeding during Pregnancy

When a pregnancy occurs, many breastfeeding women notice changes: decreasing amounts of milk, suddenly having sensitive nipples again, declining milk ejection reflex, pain during breastfeeding, feelings of reluctance. These often increase if the amount of milk decreases even more in the middle of the pregnancy or disappears entirely. In the English-speaking world, the uncomfortable feelings that are sometimes connected with this are called Breastfeeding Aversion and Agitation (See, for instance www.breastfeedingaversion.com): ›

It means negative and generally uncomfortable feelings about breastfeeding. These can occur not only during pregnancy but also with tandem nursing (see below). These negative feelings are not necessarily present throughout the entire pregnancy: Sometimes they diminish when the pre-partum colostrum production begins. On the whole, however, these feelings are practically impossible to influence. The mothers often suffer a great deal. These feelings do not reflect the feelings of the mother towards the child or breastfeeding. Nevertheless, breastfeeding possibly triggers feelings that are hard to bear, such as negativity, disgust, irritation, anger... In this situation, weaning is, of course, one solution that we as counsellors should, in any case, communicate. If the mother wants to continue breastfeeding, then some distraction while breastfeeding (reading, telephoning), taking short breaks, shortening the breastfeeds overall and/or reducing the breastfeeding frequency, may possibly help her.

What must we keep in mind when advising a breastfeeding pregnant woman?

Breastfeeding during a healthy, normal singleton pregnancy is, as a rule, not problematic. It neither makes a miscarriage more likely nor, in the absence of other risk factors, should an increased risk of premature birth be expected (Flower, 2003; Moscone, 1993).

This is different if there are already risk factors, such as premature contractions, bleeding or cervical insufficiency. In pregnancies with multiples, caution is advisable. In the presence of risk factors for prematurity, all factors promoting contractions– among them breastfeeding - should be ruled out to be on the safe side.

During a pregnancy the amount of milk often decreases, but it can also stay the same or stop altogether. This is different with each individual woman and also depends on the age of the breastfed child, the amount of milk and the breastfeeding frequency up to that point. The milk will almost never increase and it can scarcely be influenced during pregnancy using the usual measures for increasing milk production that we know and use outside of pregnancy. Many children wean themselves spontaneously when the amount of milk declines considerably; others continue with "dry" breastfeeding.

Tandem Nursing

At the end of the pregnancy, many women – including those who are not breastfeeding – observe an initial production of colostrum. After the birth, colostrum is produced as usual. Because the availability of colostrum is quantitatively and time limited, it is always necessary before the milk comes in that the newborn feed first! The laxative effect of the colostrum can also be noticed in the older baby. If the milk has come in, it can be managed in a more relaxed way and the older baby can feed when he wants to (assuming that this is all right for the mother!). The newborn can be offered both sides; the older baby can either have one side or both.

What to do when the young infant is gaining too little?

If the newborn is not putting on enough weight, experience shows that the blame is placed on tandem nursing. If there was no remarkable weight development with the first baby or if there are other risks for a reduced amount of milk, the reason must not necessarily be tandem nursing. In order to increase milk production when tandem nursing, the following modifications in breastfeeding management are helpful:

1. The new baby should always feed first. Possibly, the older breastfed child can also wait if it is foreseeable that the small baby will want to breastfeed again soon.
2. Both babies are fed at the same time. The first baby feeds on one side. When he lets go, he is offered the second side and the older baby is given the side from which the new baby has just fed.

Summary

Counselling the mother-child breastfeeding dyad beyond infancy is enjoyable, challenging and varied. The mothers are often particularly grateful to have their breastfeeding wishes still be taken seriously. And is it not also a very special form of breastfeeding promotion, in our culture as well, to support the breastfeeding of older children, who might possibly remember their breastfeeding time later on? For these children, in particular, breastfeeding often becomes a very special normality, which we need, if breastfeeding, with *all its possible facets,* is to become normal in our society again.

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Weaning – How Can I Support my Baby Attentively?

Author: Carolin T. Schallhammer

Photo: © South_agency, iStock

Breastfeed or play? Breastfeeding can be replaced, in time, with other means of regulation

In the first years of life, breastfeeding helps not only with hunger and thirst, but is also a crucial source of comfort, calming, closeness and regulation of feelings and affects. With increasing age, the child also learns alternative ways – breastfeeding will become superfluous step by step. The parents can support this emotional development process, gently and consciously, by recognizing the feelings and needs of the child empathetically and by reflecting and expressing them in words. In this way, parents and children can discover alternative ways of fulfilling these needs and finding a sense of well-being at physical and emotional levels.

Carolin T. Schallhammer, International Board Certified Lactation Consultant (IBCLC), speech therapist and trauma therapist from Salzburg, explains the connection between affect regulation and weaning and, in her article, shows how parents can support their children empathically during this emotional development process.

Breastfeeding as a basis for physical and emotional well-being

With newborns, many needs, such as hunger, thirst, warmth, closeness and security, can be met. Nature has made this easy for the parents: they don't need to be able to recognize and respond to the various needs in a differentiated way. In this already-tumultuous life change, nature gives us time to get to know our baby and to grow into the new role as parents.

For a small child, breastfeeding is the most intensive form of contact and bonding to the mother. It is a coalescence of inner closeness, comfort, empathy and calming. The need to suck is always also a need for closeness with the mother. This is what nature has interlinked – for the physical and emotional health of the baby.

The breastfeeding period is a phase of life

Children naturally "expect" to be breastfed for several years. Mammals breastfeed all the longer, the higher their social development is. Great apes breastfeed 3½ to 5 years. This too is a reason to assume a long period of breastfeeding for humans. **The World Health Organization (WHO) recommends breastfeeding up to the age of two years or beyond for the protection of children.**

If pregnant women are asked if they want to breastfeed, almost all of them will answer "yes" to this question. Very few of them will be thinking about weaning at this point. But, for most of them, it is clear: "I will certainly not breastfeed a two-year old child". However, world-wide over cultures and millennia, children have mostly breastfed between one and seven years and weaned in the most various ways – depending on the culture.

Today, many mothers who are breastfeeding for a long time had not originally planned to do that. Often, it simply "develops" because it obviously does the child good and feels right for the mother. **Sometimes uncertainties arise, primarily because the pictures and models are lacking.** In the last hundred years, it has become unpopular in the western culture to breastfeed a child so long. Furthermore, the mothers themselves mostly do not carry a body memory of (long) breastfeeding inside them that could support them on the path to breastfeeding and weaning. Critical commentary from outside aggravates the situation even more. Thus, some mothers hear the following commentary: *"What? You are still breastfeeding your child?", "You will have to go with your breast into kindergarten", If you were no longer breastfeeding, the child would sleep better/You could finally look after yourself…"* or *"That cannot be good for the child!"* Such comments unsettle mothers, who want to listen to their own intuition. No wonder that weaning becomes a "big topic".

Photo: © yarruta

Women who breastfeed somewhat older children run into strong headwinds. But breast- feeding supports the mother in perceiving and fulfilling the needs of her children.

Supporting emotional development by breastfeeding and attentive weaning

Through the birth of their child, parents are confronted with enormous adaptation and change. Before and after this stressful time, it seems unimaginable to us, how we can cope with regular getting up at night, deferring our own needs and making ourselves available. For the baby, however, it is enormously important and formative for his life if the parents can welcome him, are on the right track with his needs empathetically and can meet them and be there for their child.

The hormonal situation with breastfeeding promotes the ability of the mother to perceive the needs of the baby and to react to them. Through the hormone, *oxytocin,* which is released during breastfeeding, the mother feels an intensive attachment to her child. *Prolactin,* the mothering hormone, makes us soft and particularly open to empathizing with a small, helpless being. It's a very supportive cocktail for being a parent.

The secure feeling at the beginning of life, that physical as well as emotional needs will be fulfilled, is a defining experience for the sense of **basic trust,** the basis for how trusting, open and outgoing we are as we go through life. The ability to perceive, name and deal with our feelings and those of others, makes us social people: with compassion, empathy and both conflict- and communication competency.

BREASTFEEDING: Source for physical and emotional well-being

The wish to wean

Frequently, weaning develops from the child's side because the child finds ever more ways to meet his needs and deal with difficult situations.

Sometimes, however, the wish to breastfeed less often and also to wean, comes from the mother: *"Somehow, it no longer feels all right to breastfeed".* Perhaps the child also sends signals to the mother, to help him with the next developmental step. It is natural then, to change something: to seek new ways, to investigate what need the child is expressing with the wish to breastfeed and to find other, more age-appropriate and, perhaps, even more efficient solutions than breastfeeding.

The child learns alternative ways to regulate his feelings

The baby is dependent for his affect regulation on his parents and their physical closeness to learn how to calm himself down and relax again after he has played excitedly, cried or sometimes lain in strange arms. With breastfeeding, along with the food intake, there will also automatically be regular body contact, which also helps the child to regulate himself emotionally.

With increasing possibilities to differentiate and the child's maturation, he gets acquainted with ever more possi- ›

bilities to meet his needs and to regulate his feelings. Parents and child find other - perhaps even more effective - solutions than the breast until the child no longer needs breastfeeding. Until that point, with every breastfeed, he fills up on basic trust, closeness and, of course, high quality immune factors and food.

› As at the physical level, with the introduction of solid food, this transition also happens at the emotional level, step-by-step and at an individual pace.

How a child gets to know his feelings
Reflecting: The mother empathizes with the child's feelings and reflects them back to him with mimicry and voice (© subbotina).

A small baby does not yet recognize his needs and feelings in a differentiated way. At the beginning, it seems to be more of a global sense of well-being or lack thereof. **The child first gets to know and learns to differentiate his feelings through empathy, reflection, naming and answering from his environment.**

When a baby laughs and someone is there who laughs with him, that is, reflects his expression of feeling with mimicry and voice and can also sincerely enjoy this with him, then the baby experiences himself as a laughing being. He experiences what joy is and that it is welcome. Similarly, when he turns the corners of his mouth down and opens his eyes wide because he has just been startled: If someone is there who turns to him lovingly and empathically, reflects the feelings he has expressed and gives him support to deal with the situation, then he also learns how to manage uncomfortable feelings. He has the experience that he is also accepted with so-called "negative" feelings and that everything will be OK. Furthermore, in the interaction with his parents, he learns to name these feelings and to express his needs.

› Speech and other forms of contact take the place of breastfeeding to express and regulate needs and feelings.

When the uncomfortable feelings of the child are frowned upon or not tolerated by his environment and, at the same time, not reflected and named, then the child lacks the possibility to deal with this. He does not understand what is happening in himself and does not know what he should do with his feelings. He feels that he is not welcome with these feelings and feels rejected. The inner conflict, feeling uneasy and not being allowed to have these uncomfortable feelings, exacerbates his inner anxiety and the emotional and physical dysregulation. Thereby, the need for support for regulation increases.

Examples of how parents can support their child in verbalizing and regulating his uncomfortable feelings.

Reflection and verbalization of uncomfortable feelings:
Let's take as an example that a baby is frightened of the vacuum cleaner noise. Whenever he is frightened, upset or becomes stressed, his nervous system goes into alarm mode and sets off many survival mechanisms. A small child, with the same biological features as those of a baby of the Stone Age, does not yet know whether the loud vacuum cleaner is a life-threatening animal in attack position or only a modern harmless cleaning appliance. If there is a person he trusts with him who recognizes his feelings, reflects his expression of those feelings and verbalizes in an empathic voice *"Oh, you have just been so frightened! That was the vacuum cleaner. It is really terribly loud!",* the still-helpless baby experiences, on the one hand, that his feelings are taken seriously – independent of how the adult gauges the situation – and, on the other hand, protection and an immediate model

Photo: © subbotina

Reflecting: The mother empathizes with the child's feelings and reflects them back to him with mimicry and voice.

Photo: © Wavebreak Media Ltd

Uncomfortable feelings should also be reflected, accepted and verbalized to support the child in his affect regulation.

Photo: © oksun70

"Mama, Book!" The toddler learns about "grown-up" possibilities to meet his needs.

from whom he can learn physical and emotional regulation.

Recognizing the need behind breastfeeding:
The mother says to her one-and-a-half year old child, after the child has "hung" on her breast for a long time and she is getting restless: *"Hey, you are not letting go of me at all right now…I know, today I have telephoned a lot. Do you want to look at a book together?"* Mostly, it takes just a second until the child lets go of the breast and takes up the offer (assuming that this was the correct guess). In this situation, the child has brought the mother out of her activity and gained her attention with his wish to breastfeed. The release of the hormones during breastfeeding supports the mother in her attentive perception of the child and relaxes and slows her down. Now she knows that the child doesn't want to play by himself anymore and needs her attention. She makes him a concrete suggestion for being in contact with each other in a way other than breastfeeding. At the same time she promotes his speech development: She reflects the child's situation to him and finds words for it. The next time, the child may, perhaps, come himself and say "Mama, Book!"

In this way, the toddler learns to express his feelings and needs verbally and to find other solutions. He is now no longer exclusively dependent on his attachment persons to recognize and answer this. He has found a "grown-up" way to ensure that his needs are met and to regulate his feelings. This is a longer learning process, which, with a toddler, progresses with phases of more frequent or longer breastfeeding. This is completely natural.

› If the mother attentively and empathically observes which needs of her child are behind the breastfeeding (for example, boredom, the wish for support for the transition from one game to another, uncertainty due to a quarrel between the parents, etc.), names them and, thereby, supports the child to increasingly find differentiated solutions, then breastfeeding for comfort moves more and more into the background.

Recognizing and encouraging the child's need for autonomy.
The parents encourage the development of autonomy in their children when they sensitively perceive their individual needs and development, then support their children if they need this help or contact, but can sit back if the children are satisfied with themselves. That also involves the parents' recognizing the individual personalities of their children and not wanting to force them to accept their own solutions.

Examples:

- Does the baby need to be occupied at all or is he busy right now with a small, just-discovered thread?
- Does he need the support of someone to give him the rattle or did he want to try to roll there just now?
- Do I automatically offer the breast to help him fall asleep or go back to sleep or do I notice that the baby is open to finding his own way right now?
- Can I tolerate the child putting his outfit together himself today?
- Do I allow my child say "no"? Can he decide for himself whether he wants to sit on Grandad's lap or not?
- Can I opt out of the mother competition, if the same aged child of a friend already goes more courageously to strangers, without pushing my child to behave the same way?
- Can I protect my child when Grandma has expectations of his behavior?
- Can I also remain lovingly present with my child when he expresses his frustration because something does not function immediately?

Briefly: Can I accept my child in his very own way and give him space for his individual personality to unfold?

This requires a very flexible adaptation by the parents to the needs of the child: On the one hand, not limiting the child unnecessarily when he wants to try out his own will and personality; on the other hand giving the child support or the security of the breast when he needs this. If the parents are able to perceive the needs of the child sensitively, they promote in this way, the development of basic trust and, at the same time, autonomy and self-regulation. In addition, it is important that we parents also pay attention to our own well-being and our feelings and, once ›

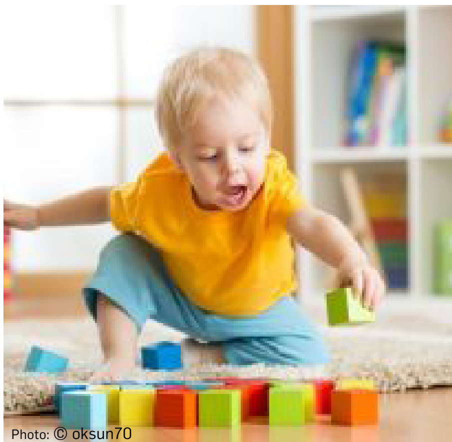
Photo: © oksun70

Please don't disturb! The child often finds completely creative solutions of his own when the parents don't interfere.

Photo: © tverdohlib

Don't refuse the breast if the child still needs it, but, at the same time, check to see if there are, perhaps, more effective solutions for the need that is behind the wish to breastfeed.

› in a while, also treat ourselves to time-out. Then we can better tune in to the fine nuances of the development of our children, deal with them more intuitively and better be there for them with their frustration and the difficult feelings. Thereby, parents also grow with their children.
A good guiding principle for supporting autonomy is:

› Don't interfere or disturb, but also don't refuse the support when the child needs it.

In relationship to natural weaning, this guiding principle can be applied as follows:

› Don't offer the breast, but also don't refuse it.

Mothers can investigate:

- Where do I breastfeed "automatically" and is the child actually no longer demanding the breast?
- Where can we easily find other solutions for the need that is behind the wish to breastfeed?

If breastfeeding is still very important for the child, then it should not be refused so as not to create a power struggle or uncertainty.
So it is that the child, over the course of the years, gets to know alternatives to breastfeeding to satisfy his needs and to feel good. He can gradually let go of the breast at his own pace and, thereby, step by step, manage his development to an autonomous, self-reliant and self-confident personality

The pacifier – a good replacement for breastfeeding?

Today, the *"pacifier"* or *"soother"* has become the symbol for infancy and toddlerhood. It is sometimes even expected of breastfeeding mothers that, in time, they will wean their children from the breast and offer them a pacifier for comfort or to go to sleep.

But is the pacifier an appropriate source for emotional balance?
What does you good when you feel alone or unwell, when you are sad or tired? For most people it is a loving person who is simply there with them, listens to them sympathetically and possible gives them support for solving the problem. It is just the same for small children. The pacifier by no means ensures that if children suck on it by themselves. The child learns a substitute behavior for breastfeeding with the pacifier or another oral habit. Statements such as *"The child uses your breast as a pacifier"* show the paradoxical development in our society.

Breastfeeding ensures contact and interaction with the mother

A child who wants to suck needs his mother. Nature has linked the two together. Nature doesn't deliver a pacifier with the afterbirth. She conceived this differently: Naturally, sucking at the breast takes place in contact and interaction with the mother. When breastfeeding, the mother turns her attention – at least partially – to the child. Mother and child experience the sensuousness together in body contact while breastfeeding. A strong resonance occurs between the two. The mother can reflect the child's feelings to him and together they may discover further possible actions to satisfy the child's needs and regulate his feelings. **This interactive learning ceases if the child sucks on a pacifier alone.**

Since neither the mother nor the child can actually conduct any other activities while breastfeeding, both have an interest in ending breastfeeding again. Therefore, comfort sucking at the breast is mostly of shorter duration than on a pacifier. The conscious or unconscious temptation to give a pacifier or allow another oral habit in order to continue one's own activities is only all too human. That does not function with breastfeeding. The mother who wants to continue her own activities rather than "still breastfeed or breastfeed once again" and the child who wants to discover the world or say something, need to discover the cause of the discomfort and find further solutions.

In order to support your child in dealing with negative emotions, **be there for your child, but also examine the need behind sucking and pursue them. Practice tolerating such uncomfortable feelings and give your child space to express them rather than suppress them.** Thereby, you ensure that the child will be seen in his needs and will develop further: At his own pace and in his own individual way.

Photo: © Diawka

For calming a small child, the pacifier has become common practice in the western culture.

Photo: © bubutu

A child who wants to suck, needs his mama

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