Lactation & Breastfeeding

Magazine of the European Lactation Consultants Alliance • www.elacta.eu • ISSN 1614-807x

3 • 2020 Volume 32

elacta
European Lactation Consultants Alliance

Dear members and colleagues,

Communication difficulties during the holiday period during the COVID-19 pandemic, the desire to illustrate the "family" model in all its diverse forms and to find authors to do so, the start of the new cooperation between the editorial team and the current ELACTA board: these are challenges that we have had to overcome even though we cannot measure the outcome in these special times.

And yet, we have once again succeeded in producing an issue that shows what is so dear to us:

Appreciative communication with creative teamwork across national borders, tolerance and openness to the lives of our mothers and families, flexibility even when presented with obstacles scientific consideration of interrelationships despite the lack of reliable data and practical help for all of us in our daily work with mothers and babies.

In the face of the global crisis, this issue illustrates the concerns we all have in these special times, in line with the theme of this year's World Breastfeeding Week:

"Support Breastfeeding for a Healthier Planet".

Mihaela Nita
President of ELACTA

Editorial staff of
Lactation and Breastfeeding

IMPRINT

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ZVR-Nr.: 708420941

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Photos: © as mentioned on the photos;
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Layout: Christoph Rossmeissl

Published quaterly at the end of March, June, September and December

Deadline: 1 January, 1 April, 1 July, 1 October

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


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Breastfeeding Counseling with Young Mothers

Author: Claudia Ruff

Photo: © iStock.com/Courtney Hale

Claudia Ruff
After studying psychology in Braunschweig and completing her doctorate in developmental psychology, Claudia Ruff began working psychotherapeutically with children, adolescents and families in 2000. She has been working as a child and adolescent psychotherapist since 2004 and as a breastfeeding and lactation consultant since 2012. In her practice, she cares for mothers in special psychosocial stress situations and babies with regulatory disorders.

Adolescent mothers and young adult mothers have special needs in the context of a breastfeeding consultation due to their particular life situation. Apart from age-specific topics, such as separation from their parental home, taking on responsibilities and the wish for freedom and autonomy, societal demands also play an important role. Continuing school and vocational training, economic dependence on their family of origin or the job center (ARGE) and, finally, the lack of everyday experience are some of the difficulties young mothers must deal with. In addition, there are their own physical and psychosocial stresses. In the present article, I describe my approach in the context of my psychotherapeutic activity with further education as an IBCLC. I would like to encourage including psychosocial aspects in breastfeeding counselling, be they via one's own continuing education or cooperation with other professionals. Breastfeeding counselling with the age group of young mothers is a complex, psychosocial challenge with great potential for individual and societal benefits.

Adolescents and Young Adults as Mothers

The stage of life for adolescents and young adults as mothers is characterized by diverse developmental tasks.[1] Among them are school and vocational training with the transition into professional life. Psychosocially, the separation from the parents and building relationships with peers are the main focal points. Thereby, adolescents mostly move within social networks, which are subject to constant modification. First partnerships are formed, frequently dissolved after a brief time, and the first sexual experiences undertaken.

With early parenthood, adolescents or young adults are virtually catapulted off the cultural and typical age development course. The possibly romantic, but far from a stable partner relationship with the other parent, takes on sustained significance. It is practically the normal case that the young partnership will not be up to the demands of family life and will break apart.[2]

A significant assumption of responsibility by the young mother is expected. She should structure her day, keep her living space clean and orderly and care for and foster the development of her child, in line with the usual expectations. With adolescents, in particular, the demands quickly lead to overload. At the same time, adolescents – but also young adult mothers – have the experience that they are, once again, dependent on the help of the older adults. Typically, their own mother and, sometimes, the mother of the young father, are deeply involved in the baby's

care. The age-specific conflict between dependency and autonomy is significantly exacerbated. The family and society expect that the young mothers will catch up on their own necessary developmental tasks or maintain them at a slower tempo.

Schoolgirls and students do not get maternity allowances[3] and only limited other financial benefits[4]. Part-time vocational training has only been offered in the last few years. It is expected that mothers in school, university and vocational training hand over the care of their children early. So extra-familial child care, even of small babies of young mothers, is also common practice. Generally, adolescent mothers are also offered social and educational support. Only in justified cases is care in a provision, such as a mother-child facility, is offered. However, partial in-patient and ambulatory care have gained in importance in recent years. In addition to outreach work, a group offering is almost always made available. The establishment of networks for early intervention pools the offerings among the cooperation partners and is already well established in many communities.[5]

Topics and Approaches to Breastfeeding Counselling with young Mothers

If a breastfeeding consultation is to be successful, it must always also address the psychosocial situation of the mothers being looked after. Frequent topics in the counseling of adolescent and young adult mothers are partially the challenges of the particular life phase, with the separation from the parental home and becoming an adult. However, there are also unexpected topics.

Counselling for the psychological and psychosocial stresses of adolescent mothers

Over the course of the last few years, pregnancies in adolescence have occurred less often.[2] However, if an adolescent does get pregnant, the experience in practice is that there are mostly other risk factors. Adolescents, who have suffered from one or more psychological disorders of pathological significance before their pregnancy, frequently present themselves. Many young mothers report an insecure or ambivalent attachment to their own parents and diverse conflicts in their families of origin, including relationship disorders. The conflicts are apparent both in the conversations with the mothers alone and also in the observation of behaviors in joint intergenerational meetings. The various types of relationship disorders and their possible diagnosis are described in the detailed guidelines of medical societies.[6] Here is a brief statement on the most frequent forms in outpatient practice:

In the behavioral observations, indications of an **over-involved relationship disorder** can be directly recorded: The adolescent/young adult is relieved of many decisions by the co-caring adult. Their practical life skills are also discussed, especially with regard to the care of the baby. Very often the caregiver, usually the baby's grandmother, accuses the infant of manipulative or "bitchy" behavior. If the young mother accepts this interpretation of the infant's behavior, the relationship disorder will be passed on across the generations.

If the young mothers become discouraged and insecure, we see signs of an **anxious and tense relationship disorder**. The young mothers show a high level of external orientation, i.e., they want to do everything right. At the same time, they do not seem to have much of a plan. Even small actions, such as undressing and dressing the baby, seem awkward and clumsy.

If adolescent mothers report under-involved or annoying, negative or abusive relationship disorders, they usually appear

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in the practice alone or accompanied by a specialist.

In parent-child relationships with an **under-involved relationship disorder**, the needs of the children are not or are inadequately seen. Caregivers pay little attention to their child. The under-involved relationship disorder is often associated with a caregiver's depression.

In the **angry-rejecting relationship disorder**, children are not perceived as equal interaction partners. Only when conflicts arise in the interaction do the caregivers react with anger and, then carry out unreasonably great consequences.

If the young mothers are frustrated and insecure, we see signs of an anxious-tense relationship disorder. The young mothers display a high external orientation, i.e. they want to do everything right. Thereby, they seem not to have a plan. Even small hand movements, such as undressing and dressing the baby, appear awkward and clumsy.

When young mothers report on under-involved or angry-rejecting or abusive relationship disorders they turn up in the practice mostly alone or in the company of a professional.

In parent-child relationships with an under-involved relationship disorder, the needs of children are not or are insufficiently recognized. Caregivers react only minimally to their child. The under-involved relationship is often associated with the caregiver's depression.

In the angry-rejecting relationship disorder, children are not perceived as equal interaction partners. Not until conflict arises in the interaction do the caregivers react with anger and then carry out disproportionately great consequences.

Many young mothers recognize the risk of triggering hostile or rejecting behavior towards their baby and ask for targeted support. A particular challenge are the survivors of mistreatment and abuse, which only allows for limited body contact with the baby. Before relaying information and skills, carrying out a therapeutic body-oriented crisis intervention has proven to be effective. The young mothers should have the experience that they can best help their restless baby with sensitivity and co-regulation. They learn that they are allowed to and should take good care of themselves in order to be able to radiate peace and security. Therapeutic body exercises, such as abdominal breathing and simple massages of acupressure points[7,8] are good to use in the crisis intervention.

After the crisis intervention, which often comprises only 2-3 sessions, the transition to information and guidance can begin. Instead of "advantages" of breastfeeding, a biopsychosocial approach is conveyed. This means: Breastfeeding is identified as normal and necessary for healthy development. The risks of bottle-feeding are clearly identified as well as the functionally advantageous use of a pacifier (preferably a limited use in certain situations). The decision for the attempt to continue breastfeeding, at least on a trial basis, will be respectfully supported. The mother will be guided to observe her baby closely[9] and receives close feedback. In the breastfeeding situation, this involves, above all, recognizing and taking seriously the first signs of hunger. Furthermore, the positive emotions of mother and baby during and after the breastfeed are made clear (to the mother). The vision of a securely attached baby, which can provide many positives for the rest of his life, is often very attractive to young mothers.

Despite all the technical and practical guidance, which is part of every breastfeeding counselling session, building the mother-child bond and strengthening the young parents in their role as mothers are essential for successful counselling. The young mothers should learn that they are the most important caregivers for their child, that they can trust their intuition, and that they can make decisions independently.

Dealing with Freedom and Responsibility

Quite normal, age-appropriate topics influence the care of the child by young mothers. Both adolescents and young adults can easily cite the advantages of breastfeeding. This is countered by the desire for free time and self-determination. Breastfeeding and carrying the baby as well as sleeping together with the child are only partially compatible with this. In addition, there is the expectation – already mentioned – that young mothers continue their education and career path as seamlessly as possible. Since the parental generation of the young mothers rarely breastfed, there is often neither previous family knowledge nor an appreciation of breastfeeding available. If the young mothers live in institutions or are cared for on an inpatient basis, bottle feeding and checking the amount the babies drink provide the professionals with a subjective sense of security when checking the quality of care for the baby. Attachment-oriented parenting behavior is often

viewed negatively. While grandmothers bring in the aspect of spoiling ("He'll get used to it if you wear him all the time"), professional caregivers still wish to have extensive intervention options. Thus it often happens that weaning is advised just in case the child has to be taken into care. Adolescent mothers are often not as assertive or confident in making decisions about their baby's care and are also very pragmatically dependent on support. The living conditions of the mother-child dyad in the mother-child facilities mean that breastfeeding mothers are very rarely found there

As mentioned above, phrases such as "Breastfeeding is best for your child" or "advantages of breastfeeding" have been well memorized by adolescent and young adult mothers. Unfortunately, it is precisely the argumentation of the "advantages" of breastfeeding that has proven to be negative in practice. Adolescent mothers often express their impression that breastfeeding is a kind of additional support, which is not absolutely necessary. On the other hand, the health risks of infant formula and bottle feeding, are not perceived as so relevant. Adolescent and young adult mothers experience themselves as isolated from their peers who, in practice, have more free time. In particular, the evening activities, such as going out, concerts etc. are missed by young mothers. Exclusive breastfeeding is not attractive in this context. The wish to have someone else step in to care for the child and have more freedom is a standard topic in working with them and must be addressed.

By contrast, the young mothers consider the assumption of responsibility to be important and desirable. In keeping with their age, they would also like to have at least a say in the care of their baby and make their own decisions. If the mothers are denied the competence for this or if too many concrete rules for the care of the baby are given, a high degree of outward orientation of the mothers can be observed. Instead of responding to the baby's needs, the baby is cared for according to supposedly correct guidelines. The sensitivity of the young mothers suffers visibly. The mothers are tense, the babies restless. Mothers then interpret their baby's restlessness either as a difficult temperament of the baby, as problematic behavior of their child or as their own inability to calm their child. Here, too, the described procedure with primary crisis intervention and subsequent cognitive support has proven itself in my practice.

Lack of Resources in the Social Net

If the young mothers come from psychosocially stressed families or if they themselves already have psychological disorders, which count as ill health, limited resources for breastfeeding support can be expected in the system. Breastfeeding guidance is associated with physical closeness. The breastfeeding counsellor and client also experience stressful situations together. Last but not least, the experience of being strengthened and valued by a specialist can lead to a close relationship with the lactation consultant, especially for young mothers.

The counsellor needs a well-thought out concept of how she would like to deal with the bond that has been created between the young mother and herself in the sense of modelling, but also for reasons of quality assurance. Good accessibility of the counsellor has proven to be of central importance. She does not have to be available all the time, but leaving messages and answering them reliably is necessary. However, if there is a necessary time delay i.e. due to the daily workload of the counsellor, the young mothers usually manage well.

Arrangements and meetings with the young mother's family of origin, with the father of the baby who may already be living separately or with other persons looking after the baby should be made in consultation with the young mother and, if possible, with her presence. As in other breastfeeding consultations, grandparents, in particular, are quick to feel criticized if the care of the baby, which was common in "their days" is being questioned. It is helpful to introduce the concept of offending to the young mothers and to exemplify this in the model. The (grand) parent generation should not be humiliated or devalued. It is by no means a matter of revealing old mistakes or making accusations. On the contrary, we can use new knowledge and good strategies to support mother and baby in their development. Grandparents often grow surprisingly well into their role as breastfeeding supporters.

More often, however, adolescent mothers have to learn to be socially competent in their new way of caring for their baby. Breastfeeding on demand, carrying and sleeping together with good safeguards are concrete strategies at this point in which young mothers can live well in a breastfeeding relationship and building bonds.

Cooperation with other professional groups and institutions

Adolescents or young adult mothers in stressful situations usually come to my practice through cooperation partners, such as early interventionists, pediatricians or midwives. Less often, the mothers are already in psychotherapeutic treatment and become pregnant during this time. At first, the focus is on the psychosocial difficulties in the mother-child dyad. The role of breastfeeding is less recognized by the accompanying professionals and family members, although there is well-prepared information for early intervention staff. [10]

Adolescent and young adult mothers are expected to continue their schooling and vocational training in the near future. Separation from the baby is experienced as painful, especially when mothers would like to breastfeed. Socially, little is known about the great resource that a breastfeeding relationship represents for the baby's entire physical and psychosocial development.

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As a breastfeeding counsellor, one quickly finds oneself in the role of having to stand up for a relationship-oriented style of upbringing with teachers, employees of the job center and social education specialists. The health benefits of breastfeeding for mother and baby are often less obvious than the risks of bottle feeding. A clear argumentation that it is a health hazard for the baby if the young mother is forced to (partially) wean her baby is unfortunately necessary in some cases. The relevant discussions or telephone calls should take place in the absence of the adolescent mother.

However, there are also many positive experiences in working with other professional groups. If cooperation is successful, interest and mutual appreciation develop, which is expressed in increased referrals from mothers with breastfeeding problems or the desire for exchange and further training. A trusting cooperation with local professionals and participation in networks for young families is worthwhile.

Conclusion

When working with young mothers as a lactation consultant, particular attention must be paid to the age-specific difficulties and working through them. The counsellor takes on different roles in relation to the people involved: counsellor, instructor, lawyer, etc. The relationship with the breastfeeding mother is less characterized by the service character of a counselling situation. Rather, a stable relationship over a longer period of time is an important aspect of supporting adolescent mothers. After relationship building and crisis intervention, after successful guidance and counselling, a phase of independence and replacement must be planned.

Breastfeeding counselling of adolescent and young adult mothers is a complex psychosocial task. The work with the young mothers is characterized by a high level of commitment and closeness. It can promote the development of a relationship-oriented educational style among the young mothers. Disadvantageous patterns of interaction, relationship disorders and traumatic experiences are then no longer passed on unfiltered to the next generation – the baby. This is a great benefit for the individual development of those affected and for society as a whole.

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Grandchildren and Grandparents

My husband and I are parents of four grown children between 28 and 40 years of age and have the good fortune that all of our children are already parents themselves. Author: Isolde Seiringer


Photo: © Isolde Seiringer

Strong feelings from the beginning

Just three weeks ago, the 8th grandchild was born and, once again, as with every pregnancy, I have experienced highs and lows, which occupied and agitated me: How will the pregnancy go? Will all be well with my daughter/daughter-in-law? How will she experience the birth? Will she have good support – even now in this exceptional Corona time? Will both of them come out of this in good health? How is the bonding going be possible and how will the first days in the hospital go? I am a lactation consultant and would, of course, wish from the bottom of my heart that my grandchildren would all be breastfed and, thereby, have a good start in life. But perhaps that also puts pressure on them? How can I be supportively there and still be invisible and in the background? These thoughts have preoccupied me before the births of all of my grandchildren – more than I had imagined – and also caused me sleepless nights. Fortunately, everything went well again. A healthy girl was born, my daughter-in-law is breastfeeding this little one again with devotion and delight. They are now in the process of growing together as a small family of four

Daughters become mothers, sons become fathers – a push into the next generation for all

I became a grandmother at 43. Our youngest son was just 10. I can remember very well that being a grandmother for the first time and handing over the role of mother to my daughter, who herself feels and knows what her child needs. I trust her, together with her husband, to decide what is right for her and her family. I have tried to see my role as just strengthening and supporting her. Fortunately, with her, this was easy because we had almost the same views about what babies need. Before the birth of my first child, I had the good fortune of getting to know La Leche League. 40 years ago, we were real revolutionaries because we also implemented this philosophy. So my daughter knew how valuable breastfeeding and bonding is. She had also observed countless consultations. For the most part, I was able to lean back and take delight in how our investment in our own child was passed on and how she fulfills her role as mother in good and more difficult times with her children. It was very similar with my second daughter.

When opinions differ

I have often asked myself, how it would be if one of my daughters-in-law had a completely different vision of how she wanted to feed and raise her children and was also able to convince my son about this. Young people today want to be independent. They are mostly well educated, confident and self-reliant. They know what they want or do not want. Many of them have fulfilling professions and manage their lives well. Decades ago, we did not have so many possibilities so the visions and wishes of the two generations might diverge. How could I, as a grandmother, bear this and nevertheless be able to be supportive? I should also not drive a wedge between a son and his wife by trying to influence him. I cannot imagine this.

And this is exactly the experience of many grandparents who lived completely differently with their own children at their time. 30 or 40 years ago, the usual recommendations on feeding babies, on bonding and child-rearing were different. How strange this must be for them to see the grandchildren being breastfed so frequently, to watch them being carried and having all of their needs attend to. Back then, they had been told the complete opposite: one must not spoil children, children must learn to know who is in charge. The mother should not react to every peep. They must be trained very early to be self-reliant

The lack of understanding by the grandparents for the way the young parents deal with their children is probably compounded by remorse and, perhaps, also wistfulness because their children and they themselves, as mother and father, were unable to experience this closeness and this feeling of security. It is certainly painful. Here, discussions are needed so that an understanding for each other can grow and the acceptance by the younger generation for the fact that the mother and also the mother-in-law wanted the best for their children and thought that they were ›

doing the best. Even if it was completely different from the way that they live with their children today.

What do parents want today?

Just like all parents in all times, they want the best for their children and they want to do it well. Naturally, they must often find their way. It is, after all, an entirely new stage of life, which begins with the birth of a child. Here, many young women and men are, at first, confronted with a feeling of helplessness and overload. They need good support and help in order to find their way. Good information is important for them but, in no case, should they be patronized. They say that they want to find their own way and be able to follow it and receive support for that. They want recognition from the grandparents of their efforts and appreciation as well as confirmation that what they are doing is good. They don't want any experiences to be imposed and they don't want to be given instructions. They welcome interest, offers of help, reliable support, but also concrete help, i.e. with ironing, cleaning, cooking, etc. It is lovely if the grandparents regularly take time to interact with the baby, respect the parents' wishes and keep agreements


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Grandparents are supporters

The Corona time has clearly shown how important and valuable the support of the grandparents is. For many young women in the online breastfeeding group, who could no longer get active support from their mothers, it was clear how very devastating this was and how helpless they felt. Their partners were not always able to fill this gap. There were problems with overload which, in other times, they could certainly have dealt with quickly. But the support of the grandparents is not just essential during babyhood. With bigger children, it has been shown how much care time is covered by the grandparents and how much relief this affords the parents. At the same time, the grandchildren have painfully experienced that they can no longer go to Grandma and Grandpa and have also suffered a great deal because of this. All the more thankfully and consciously will many now again enjoy the time together with their grandchildren.

The Role of the Grandparents

When I told my granddaughter today that I wanted to write this article, she said that it was always cool for her to have young grandparents with whom she (14) and her big brother (almost 18) could undertake so much. And yes, that was also fun for us and was always new with each grandchild. We grandparents of today are still rather fit and many of us are still employed. We can be active in sports, we love to travel and, for the most part, we are doing well financially. We enjoy the time and the regained freedom, when the children have moved out. It's another transition when grandchildren, who need us, come.

This may, perhaps, not immediately be undertaken by everyone with great enthusiasm. For me, I can say, that it is wonderful when a small child has developed so far that I, as a grandmother, may babysit, that I can once again wear, rock and calm. Or when the child trusts herself to sleep over at Grandma's and Grandpa's. And how I also feel the oxytocin flowing, even when I can no longer sleep with a child in the bed because I am not used to it anymore. The many books and games stored in the cellar are constantly hauled out and exchanged depending on what child is currently there. Activities are not just fun for the children. We too feel young and active again with them – even when we are exhausted in the evening and happy when peace and quiet return.

Children love to find out how it was when their parents and their grandparents were young. My feeling about this is that it wasn't so long ago, but for the grandchildren it was ancient times. Perhaps this is where family life and appreciation and understanding of each other have come full circle. Every time has its special characteristics. There have been good and less good things in all times Parents have always loved their children and have shown it to them in their own way.

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Fit for Breastfed Grandchildren

Perhaps it is already eagerly awaited and then it becomes reality: A grandchild announces herself and you are biologically and emotionally connected with a new citizen of the earth without your intervention. And yet your own child (the mom or dad) seems to have only just outgrown infancy.

Photo: © Isolde Seiringer

Many grandparents make every effort to support the young family with all their strength and experience. However, the recommendations on nutrition and how to handle babies have changed a lot over the last few decades.

Health for mother and child

Health is what most people want for themselves and their loved ones. And that brings us to the important subject of nutrition. Breastfeeding is the most effective and economical health care for both the baby and her mother. Breast milk is individually tailored to the changing needs of each child. The ingredients, some of which are unique, ensure optimal brain development, healthy intestinal flora and support the child's immune system. Breast milk contains living cells that are able to fend off pathogenic germs. By sucking on the breast, the baby's muscles in the mouth and jaw area are well trained so that jaw and tooth misalignments occur less frequently.

Breastfeeding women have a reduced risk of developing breast cancer, ovarian cancer and type 2 diabetes and, later in life, the risk of cardiovascular disease is also reduced. The breastfeeding hormones support mother-child bonding and reduce the likelihood of maternal depression. The positive effects of breastfeeding for mother and child are all the greater the longer the duration of breastfeeding.

Exclusive breastfeeding / duration of breastfeeding

If breastfeeding is proceeding without problems and the child is gaining weight along the course of her growth curve, it is unnecessary to feed tea, other liquids, artificial baby food or supplementary food in the first 6 months of life. In fact, such additional, but unnecessary feeding can even be harmful, upset the balance during breastfeeding and change the special intestinal flora of the breastfed child. Breast milk contains sufficient water and minerals – enough even on hot days or for a feverish baby. Additional drinks could even severely disturb the water and electrolyte balance.

Exclusive breastfeeding in the first 6 months ensures the greatest protection against numerous diseases, both for mother and child. After that, breastfeeding should be continued with appropriate complementary foods until the age of 2 years or beyond, as long as mother and child wish to do so. This is the worldwide public health recommendation of the WHO. Even after the introduction of complementary foods, breast milk remains a highly complex and high-quality food that continues to provide valuable nutrients and antibodies and quenches thirst for a long time. Even partial breastfeeding or only short periods of breastfeeding are a valuable contribution to health care.

Is the milk enough?
The more frequently and effectively the breast is emptied, the more milk is produced. 8-12 meals in 24 hours guarantee sufficient milk production. A well-known phenomenon in the first days, perhaps even weeks, is so-called "cluster feeding". Here, the intervals between individual breastfeeding meals are sometimes very short, so that the mother may have the impression that she is breastfeeding uninterruptedly for hours. Such "breastfeeding bouts" occur most frequently in the evening hours. The effect of this cluster feeding is a particularly sustainable increase in milk production.

Nutrition during the breastfeeding period
Unfortunately, nursing mothers often hear that their children's restlessness is related to their breast- milk or their diet. In fact, it is extremely rare for babies to react to allergenic food components in their mother's diet. Those substances that cause flatulence in adults do not get into breast milk. As a rule, mothers can and should eat anything they like. Only in the case of alcohol is restraint appropriate.

Body contact
Not all crying is a sign of hunger. It can be an expression of the fact that the day has been very turbulent and the child is overexcited or simply tired and exhausted. Carrying a baby is a simple, practical and loving way to provide sufficient closeness and physical contact. It has been proven that children who enjoy a lot of physical contact cry less often and have fewer stress hormones in their blood, i.e. they are more relaxed. Carrying supports breastfeeding and promotes the physical and mental development of the baby. Formerly carried children have fewer posture problems when they enter school than children who were not carried.

Sleep
Babies and toddlers waking up at night and wanting to breastfeed is perfectly normal and healthy. Frequent nocturnal breastfeeding supports milk production, prolongs the duration of breastfeeding and even provides some protection against sudden infant death. If mother and baby sleep right next to each other, they can breastfeed while lying half asleep at night and get more sleep overall than if they sleep separately. Accompanying a child into and through sleep supports the parent-child bond and the child's basic trust. She will draw on this for a lifetime.

Ask the young parents how they would like to be supported by you!
Some young families need a lot of peace and quiet for themselves. Others are happy when the grandparents take over the shopping, cooking, washing or ironing. Young parents are relieved when their grandparents are not demanding of them, refrain from giving advice and listen to them patiently and lovingly. It does them good if they are allowed to go their own way and their efforts are seen and appreciated.
Even if mother and child are an inseparable unit at the beginning, sooner or later the time will come when you will be able to participate in the care of your grandchild and deepen your relationship.

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 a 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

Becoming Grandmothers – What Does This Mean for Us as IBCLCs?

As the mother of an expectant mother or expectant father, there is an emotional tie, which is possibly so strong that it is difficult to be professional, when it is necessary and to let go without distancing yourself. Author: Elke Cramer

Photo: © Elke Cramer

Elke Cramer
IBCLC, Gynecologist and Obstetrician, member of the editorial team for Laktation und Stillen (Lactation and Breastfeeding), grandmother of two granddaughters.

In today's older generation, many of us see it as our life's task to support the young families of our children, on the one hand, as a matter dear to our hearts vis-à-vis our children and grandchildren but, on the other hand, we are also, competent experts. This task can be particularly fulfilling when it succeeds, but can also strain relations if we have the feeling that our efforts have failed, perhaps because the young family has other ideas. Sometimes, the question arises of how our support is experienced by the young couples: as advice from the mother or mother-in-law that they don't want because they want to go their own way or as valuable support from an expert?

In order not to allow these situations and the feelings associated with them to become too powerful, we grandmothers must reflect honestly on and dissociate from them. Otherwise, dealing with this will be difficult, especially if we find ourselves in a time when we are leaving our professional life, have spatial distance from our children and grandchildren and/or are juggling the responsibilities of our own professional life and being available for the young family. This is, in any case, a significant question about meaning.

The cohesion within the (extended) family can become stronger if life plans coincide. However, it can also happen that minor differences cause more separation and divisiveness. Thus many things can become a balancing act for us grandmothers, which require a good portion of "mild old age".

We have only shaped one half of the couples that we want to support. Becoming aware of this can moderate our feeling of being responsible.

However, the most important thing is that we always make it clear that we want the best for our families. And even if the visions of what is best are different, it is still a sign that we have a fund of knowledge, which we can use for the welfare of our loved ones.

Mum × 2

We are a married lesbian couple from Berlin Neukölln. Nicole is 34, Martina 39. Authors: Nicole, Martina

Photo: © Nicole

Since the time when we became a couple, we wanted at some point to start our own little family. In February 2019 we decided to fulfil our dream by undergoing fertility treatment in a Berlin clinic. Martina got pregnant after the first round of in vitro fertilization.

At this point we were already thinking and talking about whether it might be possible for me, as a mother who is not carrying a baby, but as a healthy young woman, to breastfeed our baby as well as the biological mother. My wife and I soon came across the topic of induced lactation and adoptive breastfeeding. We talked about it, but for the time being the subject receded into the background for a few months and we enjoyed our uncomplicated pregnancy. It was not until about eight weeks before Martina's due date that we arranged a counselling session with an IBCLC in Berlin. The short waiting time from the phone call to the appointment in the IBCLC's practice was nevertheless enough to make me at least have some doubts about our shared breastfeeding project. I was particularly concerned that a situation might develop between Martina and myself that would be more competitive than cooperative. We also did not know whether stimulating lactation would work at all for me, or, above all, how we should organise shared breastfeeding.

In the initial interview, our IBCLC was absolutely open and honest with us. "You can do everything the way you want." We talked for quite a while about our wishes and ideas for shared breastfeeding. At the end of the conversation, we drew up a plan together that would help us to implement our wish, and we followed this plan during the next weeks until the birth of our son.

Since, due to ignorance, we didn't contact our IBCLC until a late stage of pregnancy, and the due date was not that far away, I decided to stimulate my milk production with domperidone (30mg 3 times daily) and breast massage.

As we were going on holiday to the Baltic Sea a few days later, we decided to begin the procedure during our holiday. During this time, it was easier for me to integrate breast massage 8-12 times a day into my daily routine. And lo and behold, after about 5 days of breast massage and domperidone, my breasts tentatively began to produce the first drops of milk.

When I got back home, I realised quickly that I was going to need a double pump. As I went back to work full-time after my holiday, I was not able to do breast massage as often as I could while on holiday. I began pumping with a double pump in the morning before going to work. I pumped again several times a day, and did power pumping in the evening. And so in the end, my milk production really got going. .

By the time our son was born in January, we had already stored several hundred millilitres of my milk in our freezer. When, in the delivery room, I put our son to my breast for the first time, it was an absolutely amazing feeling.

Our son was born in an anthroposophical clinic in Berlin and we received a lot of support with breastfeeding. However, the fact that both mothers were breastfeeding the baby caused astonishment, but also admiration. Even in this very breastfeeding-friendly establishment, we were the first lesbian couple to co-nurse their baby.

As agreed with our IBCLC, Martina always put our son to the breast first, as her milk production had to be established.


Photo: © Nicole

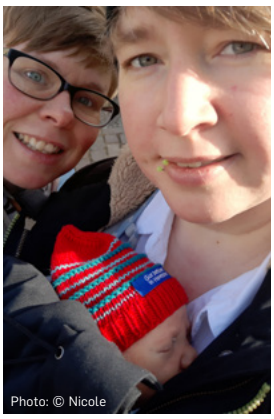
Photo: © Nicole

Immediately afterwards Paul could then breastfeed with me, which he did quite naturally. When, on the third day, Martina's milk began to flow and Paul could also drink effectively from her breasts, he started to gain weight. However, Paul and I began to have problems with breastfeeding. Looking back, they did not last long, but still the three of us went through a brief but severe nursing crisis. We not only have different breast anatomy, but my milk ejection reflex starts later. When our son was a few days old, he refused to nurse at my breast, as it was so much easier for him with my wife, and he was almost drowning in her milk.

I was devastated and felt rejected by our baby, who was then only a few days old. Whenever I tried to put him to the breast, he screamed his head off. After a day of stressful breastfeeding attempts that simply didn't work, I decided to take a break. We had to calm our nerves again and breathe deeply. I discussed the situation with our lactation consultant. She was always available for me. She supported me in my plan to take a break, but encouraged me nevertheless to keep trying to put my son to the breast. Even if he did not nurse for a long time, offering the breast was still important. So I started pumping several times a day every day, continued to take 30mg of domperidone three times a day and, on the advice of our IBCLC, we bought a supplemental nursing system. After a few days I began to offer our son my breast again; even if he only accepted this for 30 seconds or 2 minutes, it was better than nothing. In the evenings, I breastfed with the supplemental nursing system, using the milk I had pumped; at least that worked. And after about 14 days I lay down with my son in our bed, without thinking about nursing, and he latched on and breastfed lying down as if he had never done anything else. It was as if we had never had a breastfeeding problem. I was incredibly happy and relieved. From this time on, we have not had any nursing crises. In retrospect, Martina and I are incredibly happy that we received so much positive support and encouragement from our lactation consultant and from our midwife.

Martina and I were definitely not aware of how much effort induced lactation would involve. It takes a lot of time and nerves. Since I didn't have any pregnancy hormones and, instead of a long 10-month pregnancy, I only had a few weeks until the birth of our son, I am even happier today that I never gave up our plan to co-nurse, and that I almost managed exclusive breastfeeding with breast massage, pumping and taking domperidone. There is no breastfeeding competition between me and Martina. Our son is now 6 months old ,and over time we have found a way to organise breastfeeding times that suit us very well. I breastfeed our son in the mornings, pump once at work, and then take over breastfeeding again in the afternoon. At night, we take turns. To this day, I take 10 mg of domperidone three times a day as a maintenance dose. Unfortunately, so far I have not managed to eliminate domperidone completely, as doing this resulted in a steep drop in my milk production, which our son noticed very clearly. Maybe I will be able to do without domperidone in a few months. However, since I have never had any side effects from domperidone, I (along with our IBCLC and my gynaecologist) find that 30 mg per day is justifiable.

So far, we have not had any negative experience with our project. On the contrary, outsiders are surprised to hear that breastfeeding is possible without having given birth to a child.

Our son developing absolutely normally for his age. He is a relaxed and cheerful baby. It makes us happy when he lies gurgling between us in the family bed and turns to the right to nurse from Mama Nicole and after three sips lets go, turns to the left and then takes a few more sips from Mama Martina. You can see that he really enjoys this!

I, Martina, the birth mother, am very happy that breastfeeding works so well for Nicole and Paul. Breastfeeding is so much more than food. You can see this quite clearly with Nicole and Paul. I'm not sure if they would have had such an intimate, loving and exceptionally close relationship without breastfeeding. For a while, stimulating her milk supply involved a lot of organisation and stress for my wife. Then there was the nursing crisis, when our son was a few days old. The days of this nursing crisis in the postpartum period were very exhausting and the three of us lay in bed crying because we were emotionally exhausted. However, despite this, we did not lose sight of our goal and managed to find a good way to achieve it. Today I am extremely proud of my wife. Even after 6 months, it is wonderful to watch her and our son while they nurse.

We, Nicole and Martina, can only encourage every lesbian couple and every adoptive mother who chooses to pursue the path of induced lactation. It's worth it!

How an Issue of Lactation & Breastfeeding Is Created

Lactation & Breastfeeding has been published both as a German-language print edition (Laktation & Stillen) and as an English-language PDF since 2015. Lactation & Breastfeeding is the ELACTA members' magazine, but 'non-members' can also subscribe to it. The path from the idea to publication and delivery is long, with challenges of many kinds. Author: Andrea Hemmelmayr, IBCLC, Member of Editorial Team

We begin by considering what the main topic should be. It is always astonishing to discover how many facets of the field of breastfeeding and breastfeeding counselling there are. The think tank is usually the regular editorial meeting, and we are also constantly confronted by current events – such as the current corona situation. Wishes and ideas from the ELACTA board or the member associations, letters to the editor or submitted manuscripts can also influence the choice of topics and contributions.

The next step is to consider suitable articles and competent national and international authors who are willing to share their profound knowledge without payment. We look for documents or studies that fit the main topic and consider which handout could be helpful for our colleagues in their work with mothers. There is also room for current information from ELACTA and the member associations as well as interesting news that may not fit the main topic.

The submitted manuscripts must be edited in collaboration with the authors. This can take a lot of time. Finally, spelling and grammar are corrected – in both languages, of course. Then the texts are translated. The 'finished' texts and corresponding photos are forwarded to our graphic designer, who in turn creates a raw product initially with the graphic design of the German edition. This version is checked again by the editorial team and the authors and finalized in several rounds of corrections. When the German version goes to press, the English PDF is completed.

Information about the new issues of L&B has to be added to the ELACTA homepage. In the meantime, authors are asked to sign a Conflict of Interest Disclosure form, questions are created for the CERPs test, and then translated and ultimately fed into the test system. About 8 CERPs a year can be earned by reading Lactation & Breastfeeding and answering a multiple-choice test. This is half the number of continuing education points required per year for recertification.

An issue is only ready after all these steps have been completed, and by this time work on the next issue has already begun.

Of course, there are also ongoing activities that make it possible to work undisturbed on the current issues. A pipeline ensures that different people can work on different issues without losing track of the overall picture. However, this pipeline must always be maintained and adapted to current needs. The magazine is financed in part by advertising; current and potential advertising partners must be contacted and informed about new topics, and finally yet importantly, contracts must be agreed with advertisers who are interested, and invoices must be written. It is becoming increasingly difficult to convince code-compliant advertisers to place advertisements in a print medium.

A large number of subscribers support the financing of the magazine, but keeping the list of subscribers up-to-date, writing invoices and reminding people about unpaid bills requires a lot of work.

ELACTA currently has 28 member associations. It is not always easy to maintain contact with all member associations and their presidents, but the magazine is still a means of communication between the different member associations.

In addition to annual subscriptions, Lactation & Breastfeeding also offers the possibility to purchase single issues. German users can not only download the handouts from the website free of charge, but they can also purchase handouts as tear-off pads (50 sheets each). Articles on the most popular topics can now also be purchased as PDF bundles or individual PDFs, thus eliminating the need for a time-consuming search through the various issues. The website and the shop have to be updated continually.

And of course the bookkeeping must also be documented accurately and comprehensibly.

You will meet Lactation & Breastfeeding staff at various breastfeeding events and you are welcome to discuss your ideas and inputs with us.

News From the ELACTA Board

ELACTA board work is especially challenging during COVID times. We have been holding our board meetings exclusively online. We are meeting on a monthly basis.

Since we are a group of seven board members with five new members in the board, we focused our attention on introducing the new board members to their roles. It was so nice to see that everybody took to their roles and tasks very fast and soon we were talking about continuing the work done by the former board in different task groups.

We organized the first Presidents' Meeting online, with 27 participants from all over Europe and even Egypt and Australia. In the meeting, our partner EISL was represented by Gabriele Nindl and the editorial team was represented by Andrea Hemmelmayr. We talked about challenges the member associations are facing during COVID times and challenges regarding the position of IBCLCs in their countries. Andrea presented the editorial team's plans, in particular, how to earn CERPs with the magazine and the PDF packages on individual subjects.

We organized an online campaign for **World Breastfeeding Week**. Our skilled social media person on the board, Joke Muyldermans, made a very nice video with board members throwing a ball with messages for WBW from each other. We customized the Facebook profile with an ELACTA frame, created by our creative public relations person, vice-president, Christina Law-Mclean. Every day during World Breastfeeding Week, we published announcements from the different ELACTA task groups.

At the end of WBW, we announced the winner of the poster at the ELACTA online conference.

We were happy to receive very positive feedback about the ELACTA conference. With more than 500 participants, and sessions translated into Italian, the ELACTA online conference was a big success. We would like to thank the former board for the work they did to organize the conference. We would also like to thank iLactation, our partner in organising the conference, and all the speakers and participants.

Relationships with partners

We have already had fruitful online meetings with our partner EISL, represented by Gabriele Nindl. We would like to thank Gabriele for her collaboration with ELACTA. EISL is not only a strategic partner but also a sponsor of ELACTA. Important funds from EISL are used for the ELACTA magazine and for ELACTA's work.

We had another online meeting with ILCA representative, Lisa Mandell. We talked about our future collaboration, the IBCLC position, especially during COVID times, and ways of pursuing the recognition of IBCLCs. Alenka Benedik is participating on behalf of ELACTA in the ILCA 2020 virtual conference. Christina Law-Mclean made a very inspirational video presenting the ELACTA Board and its work at ILCA's conference.

Future plans

We are preparing the next Presidents' Meeting on 23rd October. This meeting will focus on recognition of the IBCLC profession.

We are preparing the next CERPs International event in May next year, in the Loire Valley in France. We will provide more details in the next issue.

Education, Research and Translation Task Group

Breastfeeding Education in COVID-19 times is particularly important and permits us to stay together and share experiences so that we can support mothers and babies.

The ELACTA Conference 2020 in partnership with iLactation was the first education project for the ELACTA Board and received a lot of congratulations from participants.

As members of Task Group Education, Research and Translation working on behalf of ELACTA Board, we are committed to supporting breastfeeding education through educational grants. For further information see the ELACTA website.

We scan scientific literature to find research on lactation care and practical assistance carried out by IBCLCs or involving IBCLCs. We posted information on the ELACTA Facebook page.

We are working on a European breastfeeding core curriculum and on the development of European standards for breastfeeding education.

Website and Social Media Task Group

In a world where digital life is becoming more and more important, but also in the year where COVID-19 took over our lives, it has become clear that social media to reach and help people cannot be ignored. As lactation consul- ›

We organized an online campaign for World Breastfeeding Week.

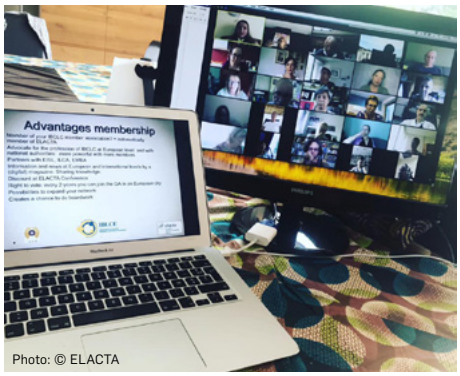

Photo: © ELACTA

Preparation for the next president's meeting on 23rd October

› tants, we have to be where the mothers and parents very often are, i.e. online. If support in person is not possible, or if encouragement on breastfeeding issues is needed, every subject can be addressed online. As members of the ELACTA board, we want to support lactation consultants in their social media activities. We have decided to create some special days. Maybe you have already noticed our posts 'Magazine Monday', 'Recognition Tuesday' or 'Wisdom Wednesday' on Facebook or Instagram. Feel free to share those posts or graphics. If you want, some graphics could even be made available in your language. Please contact ELACTA for this.

With our website, we want to invest in a European-wide listing of IBCLCs. Wouldn't it be nice if you could easily find a colleague in another country who speaks your language? Let's dream about this.

Recognition and Communication Task Group

The recognition task group focuses its activities on the promotion and the recognition of the IBCLC profession.

ELACTA wants:

- mothers to know that they can find skilled professional help in IBCLCs,
- other health professionals to know that there are specialized professionals who can help and solve breastfeeding issues to whom they can refer and with whom they can cooperate in supporting breastfeeding mothers,
- IBCLCs to be recognized by institutions, and find their place in the health systems of their own countries.

The situations of IBCLCs vary in Europe, and several different approaches could work in different environments. ELACTA wants to support each Member Association to find their way in their own country. We are working on lobbying at a European level (have you seen and signed our petition to the EU Commission? www.change.org/p/european-comission-recognition-of-ibclc-profession), and we would like to support Member Associations in developing relationships with private health insurance companies in countries where these are available. However, we also want to pursue a bottom-up approach to help IBCLCs be recognized by mothers and respected by other professionals.

We have created a Facebook group for all Member Associations to exchange experiences about the steps they are taking, what is working and what ideas they have, because we believe that reciprocal support and brainstorming together can bring strength and synergy that may help to get closer to the common goal.

Conference Task Group

Because of the special conditions due to COVID-19, the TG Conference concentrated on the online conference, which was organized at short notice on an "impromptu" basis. We were amazed by the outcome!

Now we are busy choosing a suitable location to hold our conference in Germany 2022.

Magazine Task Group

The editorial team and representatives of Elacta board are working together closely. An in-person meeting was arranged in Passau, Germany, taking into account the public health advice during COVID times (sozial distancing, wearing masks, part of team participated online).

The next topics for the magazine were decided. Weekly updates from the magazine are posted on social media.

Have you seen and signed our petition to the EU Commission? www.change.org/p/european-comission-recognition-of-ibclc-profession

Meeting of the Editorial Team With Representatives of the ELACTA Board on 17.–19.07.2020 in Passau

Even during the Corona pandemic, cooperation in a European association after a recent board election requires getting to know people in person and exchanging knowledge and experience.


Photo: © Eva Bogensberger

Above all, it is important to make our own work transparent, so we took the time to describe in detail the work and the processes that take place before the final edition of L&B is published to Alenka Benedik and Joke Muyldermans, secretaries on the newly elected ELACTA board. The two board members travelled back to their home countries, Slovenia and Belgium with many ideas that were developed together with the editorial team that they will present to the new board members.
It was an incredibly open and creative exchange that has given us the hope that we can make our magazine even more diverse and international.

With this goal in mind, we look forward to receiving your feedback in the form of letters to the editor, because dialogue with our readers is particularly helpful in enabling us to tailor our editorial work to their needs.

We look forward to continued good cooperation.

The editorial team of L&B under the leadership of Eva Bogensperger-Hezel

Establishing Bonding in the Case of Difficult Mother-Child Attachment After a Traumatic Birth During the COVID-19 Pandemic – a Case Study

To what extent can professional, resource-oriented breastfeeding counselling (IBCLC) in the early postpartum period be helpful in improving the bond between mother and child after a stressful pregnancy and a traumatic birth? Author: Petra Schwaiger

A stressful, unwanted pregnancy alone usually leads to significant emotional irritation (see Brisch, p. 70, 2013) and stress for parents. However, prenatal maternal stress can also have a negative effect on the future development of the unborn child (see Bock, p. 56, in Early Life Care, 2020).

Likewise, separation of mother and newborn immediately after birth, for example due to a medical emergency, is a severe emotional, traumatising burden for the mother (family). An acute stress reaction may occur (see Weidner, 2018). To prevent a break in the bond between parents and child, a team of psychologists, education specialists and psychotherapists would be necessary to guide and support parents well in this emergency and crisis situation (cf. Brisch, p. 131, 2013). After a traumatic birth, interaction and relationship disorders between mother and child may occur, and the mother's ability to care for her child may be impaired (see Weidner, 2018). The following case demonstrates how professional, resource-oriented breastfeeding counselling by an IBCLC can help to avoid dysfunctional interaction cascades and strengthen the mother-child bond.

The mother's pregnancy was unwanted. The first child was just 8 months old when the second pregnancy was diagnosed. At first, the mother could not imagine having a baby again so quickly, as she had suffered a lot from lack of sleep during the first postpartum weeks after having her first child.

The mother considered having an abortion. The father was open and positive about the new pregnancy.

Because of a neonatal emergency, mother and baby were transferred to another clinic and separated from one another. No initial bonding took place.

Due to the COVID-19 pandemic, visiting hours in hospitals were strictly limited. Fathers were only allowed to visit their families to a very limited extent or not at all.

In the case in question, the mother was not only separated from her newborn baby, but was also separated from her husband about two hours after the birth. The new mother was left alone in her room in the first hours after a difficult birth. For many hours she didn't know how her newborn son was doing or whether he would survive.

Mother and child were discharged from hospital after five days.

Negative factors:

- Unwanted pregnancy
- Traumatic birth (vacuum extraction, shoulder dystocia, birth weight > 4500g))
- Immediate separation of mother and infant after birth – no chance for bonding
- Baby had to be resuscitated and transferred to another hospital.
- Temporary separation from the father because of the COVID-19 pandemic
- No adequate midwife care because of the COVID-19 pandemic
- Unclear neurological prognosis of the newborn child

Case context and method

Mother and infant were supported and advised in the course of several home visits for breastfeeding counselling. The first visit took place 19 days after the birth of the mother's second child. In total, the family was visited four times and there were five telephone calls between and after visits. The mother contacted the IBCLC on her own initiative, as she had painful sore nipples and latching her newborn son to the breast was a major problem. The mother already knew the lactation consultant from a counselling arrangement with her first child. There was a good bond of trust. The case report was compiled retrospectively and descriptively as an individual case study based on direct observation.

Petra Schwaiger
is an academic expert in EARLY LIFE CARE, a lactation consultant IBCLC and paediatric nurse. She works in private practice in parent, infant and breastfeeding counselling, is a keynote speaker and a board member of the German Baby Friendly Hospital Initiative (BABYFREUNDLICH).

Case description

The son of the 36-year-old gravida 4, para 2, was born four days after the due date at the beginning of April with a respiratory adaptation disorder due to vacuum delivery and shoulder dystocia. Blood analysis from the umbilical cord revealed a pH of 6.98 and a BE (base excess) of –13.4. The Apgar scores were 3/4/8.

The baby was taken to another room for resuscitation immediately after birth; the mother did not see him. According to the mother, the resuscitation lasted about an hour. During this time, the parents did not know whether their child would survive. The child was then transferred to a neonatal intensive care unit in another clinic for further diagnosis and evaluation, as hypoxic-ischemic encephalopathy was suspected. Hypothermia treatment was considered.

The parents travelled to the other clinic to see their child. The mother was admitted to the hospital. Due to the COVID-19 pandemic and the strict hygiene regulations,

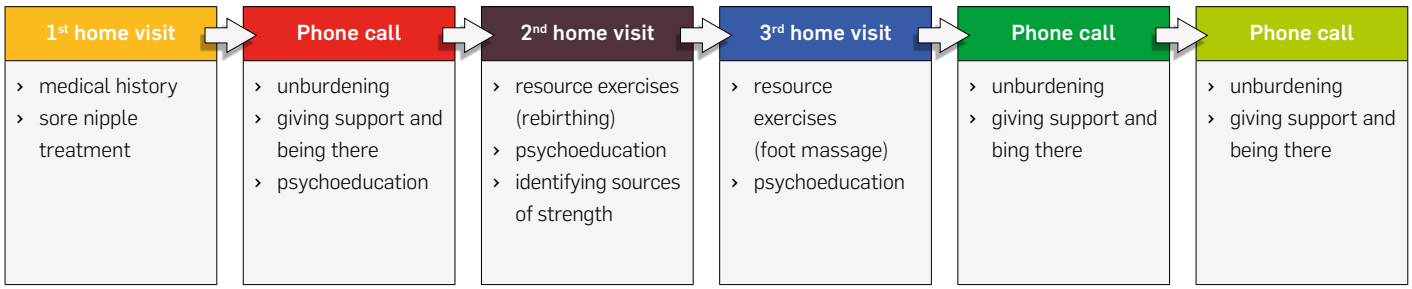

Fig. 1

the father was not allowed to stay and support his wife. The boy was cared for until 4 days postpartum in the intensive care unit, where he was in a stable general condition without artificial respiration, and then on the normal neonatal ward for two days until discharge. He was fed with pumped breast milk or formula, and there were no complications. The mother was able to breastfeed her son from the third day postpartum. Five days after the birth, mother and child were discharged together; the mother was already exclusively breastfeeding by this time. During the entire time in the clinic, there was no counselling by psychologists or psychotherapists to support the mother in this crisis situation and mitigate or prevent the development of an acute stress disorder (ICD-10 F43.0). Due to the COVID-19 pandemic and because the child was a second child, the aftercare midwife only visited the mother once.

When the child was 19 days old, the mother contacted the IBCLC she knew from her first child because she had very painful nipples.

Case approach and treatment plan

During the first (home) visit, after questioning to the mother about her medical history, the IBCLC discussed nipple treatment with the mother. At the mother's request, laser treatment of the nipples was administered to relieve the pain, and then the nipples were treated with a moist wound dressing and the so-called Vienna Breast Donuts. In the course of the case history interview and the treatment, the IBCLC noticed that the mother described what had happened to her and her son right after birth almost without emotion (emotional numbness). She appeared distant and yet overexcited at the same time (arousal).

The IBCLC did not directly mention to the mother what she had observed, but assured her that she could contact her at any time if she needed further support.

Five days after the visit, the mother phoned the IBCLC in tears, reporting that she had almost shaken her son in desperation at night and had raised her voice. She could not cope with this child's crying; her son seemed so alien to her.

There followed a counselling session in which the mother had the opportunity to express her inner need and desperation. The IBCLC suggested a possible short-term activation of resources (father, parents-in-law) to relieve the mother. A timely second home visit was arranged.

The IBCLC informed the mother that her feelings were understandable and comprehensible; inconsolable crying can be very overwhelming for parents and push them to the limits of their capacity.

During the session, the mother was informed about ways to prevent shaking the baby:

- Put the baby down in a safe place.
- Leave the room for a short time.
- Take deep breaths.
- Check on the baby every few minutes.
- Get help, when necessary.
- Contact addresses, 24/7 emergency rooms

(From: www.elternsein.info/schuetteln/gefahr-schuetteln*)*

Treatment method

The focus of the second visit was on establishing bonding. As the mother's nipples were no longer painful by this time, she was open to this intervention.

For this purpose, the newborn baby was placed naked on the mother's naked upper body (rebonding) in a warm environment, just as would normally happen after a birth. The little boy started to search for the nipple all by himself and started suckling calmly and easily. The mother was instructed to breathe deeply into her abdomen and concentrate fully on her baby. The mother was receptive to these 'rebirthing units' and was able to integrate them into her daily life.

Brisch (2013) writes that the 'window' for establishing bonding remains relatively open throughout life. This was reassuring for the mother. After the intensive 'cuddling' session, the IBCLC discussed alternative soothing methods with the mother, such as a special form of relaxing foot massage for babies (complementary medical approach). At the same time, the IBCLC and the mother developed strategies for preventing stress and activating available resources

Treatment plan and aims

It was evident that the mother was suffering from an acute stress reaction (ICD-10 F43.0) and needed more extensive psychological support in order to come to terms with the events surrounding the birth. However, because of the COVID-19 pandemic, it was difficult to find a suitable therapist at short notice. The focus was therefore on stabilizing the mother, giving her security and support and making the situation manageable and comprehensible for her, in line with the S.O.C. (Sense of Coherence) (cf. Meier Magistretti, Topalidou, Meinecke, 2019). It was reassuring for the mother to know that she could contact the IBCLC at any time and find reassurance and comfort. It was helpful that a relationship of trust already existed.

In addition, a number of structuring and relief measures were introduced (hanging cradle, baby wrap, and home help).

Treatment effects / impacts

As a result of becoming aware of her own sources of strength and the resource exercises (rebirthing, foot massage), the mother was able to relax and get to know and learn to "read" her child better. She understood better why her child was crying and what he needed. The mother's ability to care for her child was strengthened and she was able to forge a relationship with ›

him. As a result, the mother was able to respond sensitively to her child's needs and mother and child were calmer and more relaxed.

Discussion and limitations

It is quite clear that an IBCLC cannot replace psychotherapy or a psychologist. As a rule however, lactation consultants IBCLC are well trained in providing support and relief for mother and child in crisis situations until more extensive help can be obtained. Even women who are sceptical about psychotherapy sometimes find their way there by this route. Interdisciplinary cooperation in this context is therefore of crucial importance. Training courses such as the EARLY LIFE CARE course (see box) can make an important contribution to improving the situation of parents.

Consequences/outlook and recommendations for practice

During the COVID-19 lockdown, the support systems for parents in distress collapsed almost everywhere. This situation entails a high risk of additional problems (consequential damage). Vulnerable families were sometimes left to fend for themselves without help during this period. When planning interventions in the case of future infectious diseases (epidemics/pandemics), consideration needs be given to how parents who have been exposed to stress can continue to receive good care that facilitates bonding at the time of birth and afterwards in compliance with the necessary hygiene measures (face masks, social distancing, and washing hands). There should also be a debate about whether strict visiting rules should also apply to fathers, especially if their newborn children are in intensive care. Exceptions would definitely make sense in such cases.

For further research

Strict visiting rules for fathers should be reviewed with regard to whether they are effective and whether they could have negative consequences for fathers' attachment behaviour.

The impact and effectiveness of professional breastfeeding counselling by IBCLCs should be investigated in further case reports and in qualitative and quantitative studies, not only in terms of breastfeeding success, but also in terms of mother-child bonding.

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early life care Universitätslehrgang

PARACELSUS MEDIZINISCHE PRIVATUNIVERSITÄT

The university course Early Life Care, which is offered in cooperation with the Paracelsus Medical Private University and St. Virgil Salzburg, is an in-service educational program that is unique in Europe.

The goal is the establishment and exchange of multi-professional expertise, the development of multi-professional cooperation and qualification for management functions and leadership positions in the development of nationwide support, counselling and treatment services.

www.earlylifecare.at

All professional groups working in the field of early intervention, including pregnancy, birth and the first year of life, study together for six semesters, because learning together with groups from different professions is an important basis for cooperation in everyday professional life.

Severe HSV-1 Mastitis in a Breastfeeding Mother

This case study describes the early clinical signs of HSV-1 mastitis and outlines the treatment and outcome of a severe HSV-1 infection on the nipples and breasts of a breastfeeding mother.

Author: Caoimhe Whelan, IBCLC

The main issues for the mother in this case study were the sudden appearance of painful lesions on both nipple-areolar complexes, the difficulty in getting a conclusive diagnosis of HSV-1 from primary healthcare providers, and the temporary cessation of breastfeeding.

There are two types of herpes simplex viruses; Herpes Simplex Virus type 1 (HSV-1), which is mainly transmitted by oral-to-oral contact to cause cold sores, and Herpes Simplex Virus type 2 (HSV-2) which is transmitted by sexual contact and may cause genital herpes. Most herpes infections are asymptomatic, but once an individual is infected, the virus travels to sensory ganglia where it remains dormant for life. Following an initial herpes infection, periods of activation can occur sporadically (Groves, 2016).

According to the World Health Organisation, in 2012 HSV-1 affected 67 % of the world's population under 50. The most common sites for HSV-1 infection are around the oral cavity and genital area. However, HSV-1 can affect any skin mucous membrane surface. One uncommon site is the breast and nipple-areolar complex. Only 2 % of all extragenital herpetic lesions involve the breast (Brown et al, 1996). This case report describes the diagnosis, treatment and outcome for a breastfeeding mother who developed a severe and systemic HSV-1 infection. It started with herpetic lesions on her nipples, which spread rapidly to her breasts, chest, neck, face, and eye area. At the time of her diagnosis, the mother was breastfeeding her eighteen-month-old infant. The infant remained asymptomatic. The mother was hospitalised for a period of five days, but protected her milk supply using hand expression, and resumed breastfeeding after she was discharged. The biggest challenge for the mother was getting a conclusive diagnosis of HSV-1. She saw two doctors before presenting at a hospital accident and emergency department. One doctor suspected a bacterial infection while the other diagnosed infected eczema. I hope that the photographs included in this case study, which were taken by the mother during her period of infection, will be helpful for healthcare professionals and lactation consultants in the early identification of HSV-1 on the nipples and breasts.

Very few case studies of HSV-1 in a lactating or breastfeeding mother have been documented. Four were found (Amir, 2004; Boyd, 2009; Field, 2015; D'Andrea and Spatz, 2019). Three of these case studies documented an HSV-1 infection in the neonatal period, while one documented HSV-1 in a mother who was breastfeeding fifteen-month-old twins. In one of these case studies (Field, 2015), the infant was a neonate and died nine days after birth with hepatic failure and disseminated intravascular coagulation. The suspected mode of transmission was breast lesions, which had not been identified as HSV-1. In this case study, it was never conclusively determined whether the mode of transmission of HSV-1 infection to the mother was via the infant or the woman's husband, who had a history of cold sores. However, the route of transmission in HSV-1 on the nipple and breasts is predominantly infant to mother (Toussaint et al, 2016). In this case, the infant had fluid-filled blisters in her mouth two months prior to the onset of the mother's infection. These blisters are consistent with symptoms of herpetic gingivostomatitis. The sores did not seem to cause the infant discomfort and they cleared up within a matter of days.

History and Observational Assessment

A thirty seven-year old gravida 2, para 2 mother who had been breastfeeding her child since birth without any issues, noticed a painful red lesion on the underside of her left nipple, approximately ›

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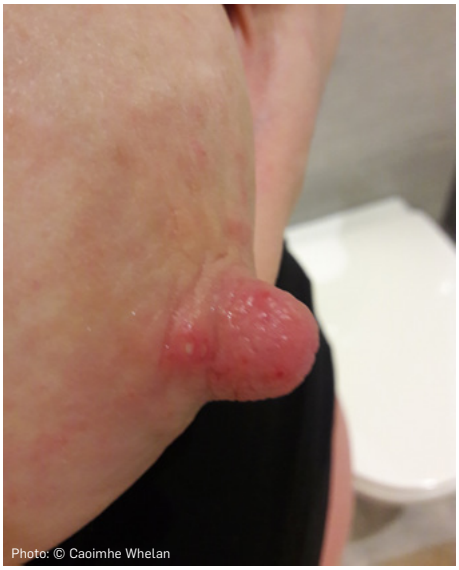


Fig. 1: Left nipple Day 1

Fig. 2: Left nipple day 2

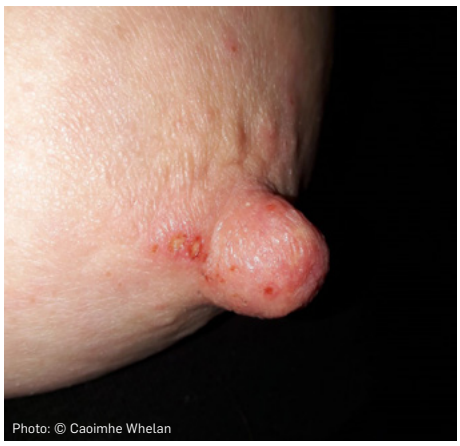
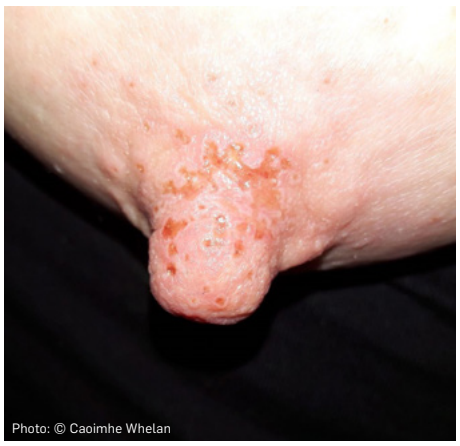


Fig. 3: Right nipple Day 3



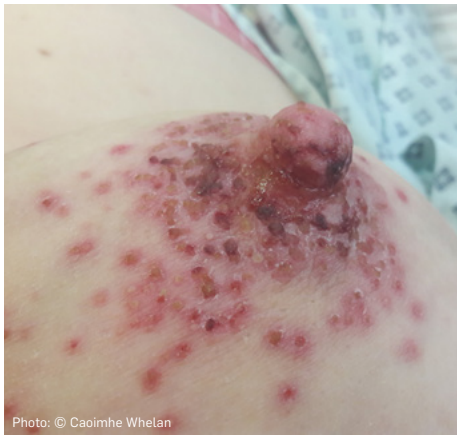


Fig. 4: Right nipple day 4

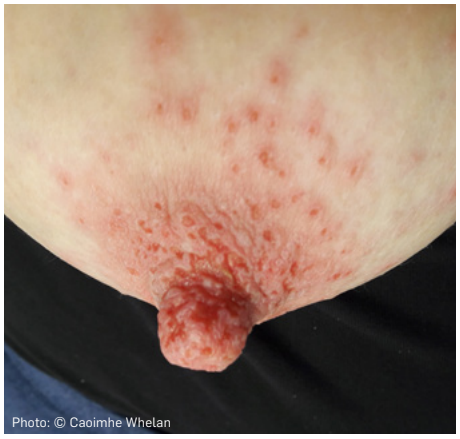


Fig. 5: Left nipple day 6

1 mm in diameter (she described it as a "red spot with a grey middle") (***Fig. 1***: Left nipple Day 1). The next day she noticed a cluster of lesions on her right nipple and areola. Breastfeeding on the right breast became very painful so the mother stopped breastfeeding from this side. She continued to feed on the left, as she found the pain on this side tolerable (***Fig. 2***: Left nipple Day 2). The mother's health history was unremarkable. She had never had HSV-1, HSV-2, shingles, breast lesions/trauma or immunosuppressive conditions. She had had chicken pox as a child and hand, foot and mouth disease (enterovirus) four years previously. She occasionally got bouts of mild to moderate eczema.

The mother tried using silver breast angels on her nipples for pain relief, but they didn't help. The next day, the mother saw an IBCLC, who suspected the lesions were viral. She referred the mother to her doctor, who suspected a bacterial infection and prescribed Fucidin H, a topical cream containing fusidic acid (antibiotic) and hydrocortisone acetate (steroid). The mother continued to breastfeed her child from the left breast, despite ongoing pain. (***Fig. 3***: Right nipple Day 3)

The mother found that applying Fucidin H to her nipples made them worse, so she stopped using it and applied breast milk instead. She felt this eased the redness and the pain.

The lesions started to spread to the mother's breasts and neck. She developed a temperature and felt feverish. She started to feel pain in her eye. She visited a second doctor, who diagnosed infected eczema and prescribed oral antibiotics and antibiotic eye drops. The mother was unhappy with this diagnosis. Her condition continued to deteriorate, so that evening she presented at an Accident and Emergency department of a large hospital. She was admitted immediately, placed in an isolation ward, and started on IV antibiotics (Flucloxacillin), IV antiviral medication (Aciclovir) and paracetamol. (***Fig. 4***: Right nipple Day 4)

Management

The mother spent four days in hospital. She stayed in an isolation ward and was kept on IV antibiotics and antiviral medication. Her eye was checked by an eye specialist, who determined that only the surrounding tissue was affected, rather than the cornea. The mother also saw a dermatologist, who ruled out eczema herpeticum.

Some of the lesions on the mother's breast became pus-filled (swabs subsequently identified the presence of a staphylococcus aureus infection, in addition to HSV-1) Clusters continued to spread to her neck and face. Some appeared on her back, her arms and on one of her thumbs. The dosage of IV antiviral medication Aciclovir was increased from 500 mg to 750 mg per day. Antiviral ointment was applied to the mother's eyes. For the duration of the hospital stay, the mother maintained her milk supply by hand expressing from both breasts two to three times per day. This milk was discarded. (***Fig. 5***: Left nipple Day 6)

After three days on IV medications, the herpetic lesions started to scab over and the swelling subsided. 'Disseminated Herpes Simplex' and Chickenpox were suspected. HSV-1 was only confirmed three weeks later due a delay with culturing swabs that were taken on admission. Following her discharge from hospital, the mother continued to take oral antibiotic medication for another two days and oral antiviral medication for two weeks. She was advised to apply a corticosteroid cream. The mother continued to hand express milk two to three times per day while her nipples healed. (***Fig. 6***: Infection on day 7)

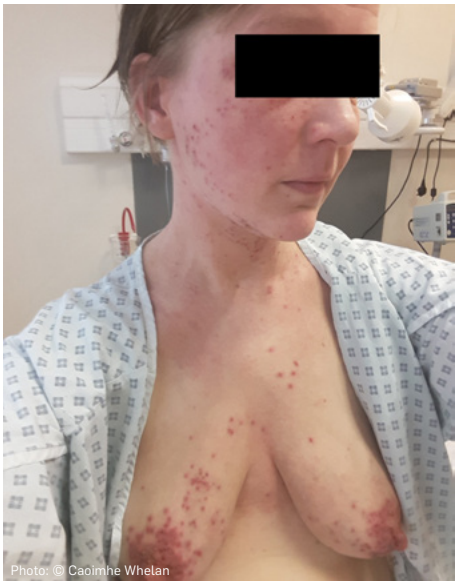


Fig. 6: Infection on day 7

Four days after she was discharged from hospital, the mother resumed breastfeeding from her left breast. The right nipple was still painful to feed from, so it was another two and a half weeks before feeding resumed on that side.

Outcomes

The mother made a good recovery and at the time of writing this case study, she is still breastfeeding her child, who is now almost four years old. The herpetic lesions completely healed over a period of weeks following discharge. However, the mother has had periodic flare-ups of both eczema and herpetic lesions in the two years since then. As a result, she is on a low maintenance dose of the antiviral medication Valacyclovir. The mother reports that the HSV-1 outbreaks are premenstrual and related to fluctuating hormone levels. The view of the mother's dermatologist is that the HSV-1 lesion outbreaks are caused by poorly controlled eczema, but the mother disagrees with this contention. She was advised to use a topical steroid cream to treat the eczema, but has refused, as she feels it makes the herpetic lesions worse.

Since the mother's initial HSV-1 infection, her child experienced one cold sore infection on her lip.

Conclusion

HSV-1 on the nipple-areolar complex is rare, but can very quickly escalate and spread from just a few small lesions on the nipples to clusters of lesions on other parts of the body. The lesions on the nipples and areolas of an infected mother are very painful and can make continuing to breastfeed difficult. Early identification and diagnosis of HSV-1 is critical to initiate appropriate treatment and prevent further spread of the condition.

Even though HSV-1 on the nipples is rare, it should be included in the differential diagnosis of nipple pain where there are lesions, spots or the appearance of a rash around the nipple-areolar complex. All healthcare professionals and IBCLCs who may see breastfeeding women should be familiar with the early stages of HSV-1 on the nipples, and they should make it clear in their referring documentation that their view is that HSV-1 is suspected and should be investigated.

Timeline

Day 1: The mother noticed a small red lesion on the base of left nipple.

Day 2: Lesions appeared on the base of the right nipple and on the areola (more specifically, on the Montgomery tubercles). The lesions were sore to touch. The mother also noticed small fluid-filled blisters in the corners of baby's mouth.

Day 3: The nipples were sore. The mother tried using silver breast angels but they didn't help.

Day 4: The nipple pain worsened. The mother saw an IBCLC, who referred her to her doctor, who diagnosed a bacterial infection and prescribed Fucidin H. The mother continued to breastfeed, despite worsening pain.

Day 5: The mother discontinued feeding from the right breast and commenced hand expressing. She stopped using the Fucidin cream as it was making the nipples worse. She started to apply breast milk. Clusters of lesions appeared on the mother's neck and she started experiencing flu-like symptoms. She got a blocked duct in her right breast.

Day 6: The mother had a temperature and was feeling very feverish. She started to feel pain in her eye. The lesions were spreading. She went to a second doctor, who diagnosed infected eczema and prescribed oral antibiotics and antibiotic eye drops. In the evening, the mother presented at the accident and emergency department of a large hospital. She was admitted immediately, placed in an isolation ward, and given IV antibiotics and antiviral medication. Blood tests were carried out. The mother was given paracetamol.

Day 7: The mother's eye was checked by an eye specialist who determined that only the surrounding tissue was affected, rather than the cornea. The lesions on the mother's breasts became pus-filled.

Day 8: The lesions spread to the mother's neck, face, back and arms. The dosage of antiviral medication increased. Antiviral ointment was applied to the mother's eyes.

Day 9: The lesions started to scab and the swelling started to go down. 'Disseminating Herpes Simplex' and Chickenpox were suspected.

Day 10: The mother was discharged from hospital.

Day 14: Breastfeeding resumed when the scabs fell off the mother's nipples.

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Expression of Breast Milk: Experience From a Project in Bangladesh

Author: Rukhsana Haider, MBBS, MSc, PhD

A peer supporter is assisting a mother with hand expressing breast milk. The mother's son is watching.

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Background

When I started thinking about writing this article, the first step was to look for recent publications and online resources that could be easily accessed. Accordingly, I googled "expression of breastmilk", and this is what came up:

"Expressing milk means squeezing milk out of your breast so you can store it and feed it to your baby later. You might want to express milk if: you have to be away from your baby, for example, because your baby is in special care or because you're going back to work or your breasts feel uncomfortably full (engorged)." (NHS, 2019).

Another simple statement is from a review that refers to expressing breast milk as "the removal of milk from the breast by other means than the baby sucking. Milk may be expressed by hand or by manual or electric pump" (Becker, McCormick, Renfrew, 2008).

The above statements are basically what pregnant and lactating mothers need to know about milk expression. Further details of how milk should be expressed, stored and fed to the baby when for any reason mothers are unable to breastfeed directly can be accessed from the excellent resources available online (those developed by Dr Jane Morton at Stanford University, other organizations and experts in the references given below), or from lactation consultants or peer counsellors.

In Bangladesh, expression of milk has generally been associated with expression of colostrum. It was a traditional practice to squeeze out the colostrum (called shaal dudh) and discard it because women thought it was dirty or old milk. Some women squeezed out and discarded only the first few drops, while others continued to discard it for the first three days until the "white milk came down". Fortunately, as a result of years of advocating, campaigning and disseminating national breastfeeding recommendations through television, radio, health and nutrition workers, most people say they have heard that colostrum should not be discarded, and that babies should be exclusively breastfed (given only breast milk, not even water) for the first 6 months of life. In our Foundation's programme areas in Dhaka and Chattogram, we have been counselling pregnant and lactating women to breastfeed exclusively for the past twenty-five years. It became obvious that when more women started entering the labour force, and then became pregnant, the practice of exclusive breastfeeding started to decrease. When women were asked whether they had heard that employed women could also continue exclusive breastfeeding by expressing their breast milk that could be fed to their babies by a family member when they were away at work, the answer was invariably "no".

The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) have clearly stated that breastfeeding is an unequalled way of providing

ideal food for infants. They state that the choice of the best alternative is expressed breast milk from an infant's own mother, breast milk from a healthy wet-nurse or a human-milk bank, or a breast-milk substitute fed with a cup. The two organizations (in the same document), also state that women in paid employment can be helped to continue breastfeeding by being provided with minimum enabling conditions, for example paid maternity leave, part-time work arrangements, on-site crèches (baby care rooms at the factories), facilities for expressing and storing breast milk, and breastfeeding breaks (WHO & UNICEF, 2003). Employed women in Bangladesh are generally not aware of this information. However most stakeholders are aware and concerned about employed women and their children's health and nutrition. So while UN agencies, government and non-government agencies were planning and conducting meetings for improving legal standards related to maternity policies and facilities for breastfeeding at workplaces, we decided to go ahead and do what we could for employed women ourselves. We started by providing peer counselling services to women employed as factory workers in a project that was conducted from May 2015 to March 2017. Peer counsellors were trained to provide home-based counselling to pregnant and lactating factory workers from 6 months of pregnancy until infants completed 6 months. The results were extremely encouraging. Of the employed factory workers, 107 out of 125 (86 %) were exclusively breastfeeding at 6 months (Haider & Thorley, 2019). One of the key factors for this success was the emphasis placed on hand expression of milk. We began by providing information about the process given during pregnancy counselling visits, and later offered demonstrations and practical help with expression after the baby was born, including involvement of the caregiver (who would care for the baby in mother's absence) to store, warm and feed the expressed milk with a small cup or spoon. The technique of hand expression as explained by the peer counsellors is shown in the Box below. The technique can been seen very clearly in several excellent videos that are now freely available online (please see references below).

Technique for expressing milk

Sit comfortably and hold the container near your breast. Put your thumb on your breast above the nipple and areola, your first finger on the breast below the nipple and areola, opposite the thumb.

Support your breast with the other fingers.

Press your thumb and first finger slightly inwards towards the chest wall, but do not press too hard or it will block the milk ducts. Press and release, press and release until the milk starts flowing out. Press the areola in the same way from the other sides. Express one breast for at least three to five minutes until the flow slows, then massage and repeat the process.

Reports from programme areas

While some mothers had used milk expression to relieve engorged breasts in the early postnatal period, daily expression of mother's milk specifically for feeding infants was previously unheard of in our programme areas. When the peer counsellors started to promote it in our project, family members were worried about the safety of the expressed or stored milk. These worries were laid aside when they saw that the babies did not fall sick. They actually grew well and remained healthy and active.

Readers of this article must be wondering how it was possible for a factory worker, working long hours, to breastfeed exclusively even for a few months. So here are some examples of factory workers' experiences. Nasima, a 25-year-old female, had been employed in a ready-made garment (RMG) manufacturing factory for six years. When she was 7 months pregnant with her second child, her husband, a cycle rickshaw puller, died in a road accident. Extremely upset and sad after his death, she moved from her husband's house to her mother's home with her 6-year-old son. At the same time, she resigned from her job, thinking that she would not be able to buy powder milk for the newborn baby and care for him/her if she was away at work. Soon afterwards, the local peer counsellor went to the mother's house and heard about Nasima's family problems and her decision. The peer counsellor (Moni) ensured Nasima that she would be able to continue working after her baby was born because she (the peer counsellor) would show her how to express her milk and breastfeed the baby so there would be no need to buy powder milk. Moni counselled Nasima a few times during the last month of pregnancy, and explained to her and her mother about the benefits of early initiation of breastfeeding and of exclusive breastfeeding, how to express breast milk, store it and feed the baby. Nasima's mother said she would help her daughter with housework and would feed the baby the expressed milk in her absence.

Nasima gave birth to a baby girl at home and named her Shimu. When the peer counsellor Moni visited them the following day, the grandmother informed her that she had helped her daughter put her baby to the breast right after delivery, and that Shimu had taken colostrum within 1 hour. A few days later, Moni helped Nasima to express her breast milk, explained again how to store the expressed milk and showed the grandmother how to warm the milk and feed the baby with a small (medicine) cup or spoon. As suggested by Moni, Nasima expressed breast milk regularly at home, so she could remain in practice, and be able to express easily when she went back to work. Slowly she became more confident, and 65 days after delivery, she rejoined the same factory.

Nasima told our monitoring staff that she had bought three plastic contain- ›


Photo: © Rukhsana Haider

A grandmother is giving her grandchild his mother's expressed breast milk via a medicine cup.

› ers to collect and keep the expressed breast milk. In the morning, she first breastfed Shimu directly, and then hand expressed her milk from the other breast in a container that she left at home. At 10 am, she expressed milk in the factory (in the corner of the canteen during tea break) and when the grandmother took the baby to the factory, Nasima went to the gate, breastfed her and gave the second container with the expressed milk to her mother. Her mother warmed this milk at home and then fed the baby with a small medicine cup. At 12 o'clock, Nasima expressed her milk again in the factory (in the third container). At 1 pm, she came home for lunch and left the expressed milk for the next feed. At 2 pm, she went back to work with the morning's empty container. When the baby woke up from her nap (about 2 hours later), the grandmother fed the expressed milk to the baby, and went to the factory again to bring back the third container of expressed milk (this time without the baby, who was left with a neighbour). At 6 pm, Nasima came home, washed up, breastfed and took care of the baby. She breastfed frequently at night, which she found easy to do as the baby slept with her.

During her monitoring visit, our staff observed that Nasima managed to hand express very well and that she had plenty of breast milk. Nasima said she did not think there was any need to buy other milk for the baby. She was happy that she could work in the factory and her baby was also growing well (as seen on the growth card). Peer counsellor Moni measured baby Shimu's weight regularly. Her birth weight was 2.8 kg, she weighed 3.8 kg at 1 month, 4.6 kg at 2 months, and, at this 3-month visit, Shimu's weight was 6.1 kg. Nasima said that whenever she faced any problem she would talk to Moni apa (big sister), who advises, helps and encourages her. She was very grateful to Moni apa and to the TAHN Foundation for employing her to provide these services at home and wished that all pregnant workers and those with small children could get these kind of services that are so essential for working women.

(Please note that all the names have been changed in this case study).

While many of the counselled factory workers could go home during lunch break, very few had family members who could take the babies to the factories to be breastfed. This was either because the factories were not close by, there was no day care facility, or because the workers could not come out of the premises during work hours. There were, however, several factory workers who managed to express their milk 2-3 times while they were in the factory, and they brought the containers home during lunch break, or when they returned home in the evening.

Another factory worker said that she used to wake up very early and while baby was still sleeping, she would express her milk first and breastfeed later after he woke up. She could hand express twice in the factory where she worked as a Machine Operator: once during lunch break, and another time around 3.30 pm. She kept the expressed milk in two containers that she kept in the fridge, and took them home at 4.30 pm. She was lucky to have had shorter working hours allowed for mothers of babies below six months while mothers with babies older than six months worked until 7 pm. After reaching home, she first breastfed the baby. Around 9 pm, she expressed again and kept the milk in the fridge. So she had four containers (maybe about 100 ml each) for the next day. She would breastfeed all night. Her mother cared for and fed the baby when she was at work. She was very happy that she could breastfeed her baby exclusively for six months, and that her baby had grown well on her milk and weighed 8.2 kg.

Family support was crucial to enable the workers to continue exclusive breastfeeding. Although initially they were doubtful about using a cup/spoon for feeding, when the dangers of bottle feeding were explained, most of them understood and were very cooperative. As one of the grandmothers said, *"I never knew such a small baby could drink from a cup, but see he does it so well."* And the grandfather (father-in-law) said: *"We thank this apa (the peer counsellor) for teaching our daughter-in-law how she can provide her milk for the baby, even though she goes to work in the factory. Of course we know mother's milk is best for the baby, and now we also save money, as we don't have to buy tin milk".*

In addition to institutional barriers (lack of space/privacy to express milk, no nursing breaks), there were some personal constraints that led to discontinuation of exclusive breastfeeding. These were real or perceived problems after delivery, concerns regarding expression or the sufficiency of expressed milk, unsupportive attitudes from mothers-in-law or caregivers, reluctance to feed the expressed milk, or the location of the factory being too far for the worker. One worker said, *'I tried, but could not express any milk after 4 months.'* Another worker said that she travelled to the factory by bus, and that it took one and a half hours to go and about two hours to return. She expressed milk at 4 am, then breastfed the baby directly. She could express

milk once only in the factory's canteen and kept it in a cooler (flask). At home at night, before going to sleep, she expressed again. This milk was enough for the baby until he was three months old, after which she could not get any milk by hand expression. Then she had to add tinned milk. This worker was sad, saying that if her factory had been close by, she could have fed him only her milk for six months, but travelling daily like this made her feel very tired.

There were other workers who said, *'I do not get time off the floor (factory) to express my milk'*, and, *'I had to do overtime at the factory. I felt tired and could not express enough milk.' 'My factory is far, and I do not come home for lunch. There is no room where I can express milk. I don't want to go to the toilet to do this.'*

In our project, the peer counsellors were the most common source of breastfeeding information and practical help. Practical advice on how to express effectively, the frequency and duration of expression, milk storage, general support and encouragement, similar to what has been mentioned elsewhere (Leurer et al, 2020) was requested by the workers and their families. In an Australian study, very few women preferred to use hand expression. The authors presumed that breast pump marketing may have led to a perception that breast pumps are the normal and only way to express breast milk (Clemons & Amir, 2010). (Some of our factory mothers had heard about manual breast pumps, and tried using them with little success. They had not heard about electric breast pumps, but these would not have been affordable). There are concerns that marketing of breast pumps could potentially create a dependency and diminish women's confidence in their ability to use hand expression. This was accurately predicted by Van Esterik (1996). She also wrote, *"the popularity of breast pumps may lead professionals to overlook the technique of hand expression. In the future, health professionals may not be taught this skill and therefore women may not be familiar with hand expression. Therefore, families unable to afford to buy or hire a pump may not be able to choose the alternative of hand expressing unless an effort is made to ensure that the practice of hand expression is included in health professionals' training"*. We hope that our article will help to increase employed mothers' confidence in their ability to hand express their milk so that their babies can be exclusively breast milk fed and directly breastfed for the first 6 months of life.

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Early Childhood Caries and Breastfeeding

Considering Tongue Dysfunction, Oral Restrictions and Mouth Breathing

Author: Anita Beckmann

In my practice, I often counsel concerned parents about breastfeeding during and after the eruption of the baby's first teeth. Unfortunately, the information provided by many paediatricians and dentists is insufficient, and this leaves parents feeling insecure. Many mothers are advised to wean their babies as early as early as the sixth month of life, as breastfeeding after tooth eruption is equated with the development of early childhood caries. Particularly if there are changes in the dental hard tissue, breastfeeding mothers are often accused of harming their children. However, other factors, such as free sugars in complementary foods, suboptimal oral hygiene and sometimes an unphysiological sucking pattern, play a much greater role in the development of caries.

Anita Beckmann,
independent dentist, breastfeeding counsellor (Stillbegleiterin DAIS); specialised in holistic treatment of craniomandibular dysfunction (CMD); since 2017 specialised training in oral restrictions, has been giving lectures since 2019; 2 children (2014/2017) with too short lingual frenula

How caries develops

Caries is an infectious disease mainly caused by the bacterium Streptococcus mutans. It develops when these germs convert dietary sugar into acids over a longer period of time. The bacteria attach themselves to each other in the oral cavity together with other microorganisms and form a network of bacteria, food remnants and saliva components on the tooth surface. This network is called plaque or biofilm.

The acids formed in plaque demineralise the enamel, i.e. dissolve minerals from the enamel. If the enamel becomes porous, microorganisms can penetrate the tooth and destroy it from the inside. With a balanced diet, saliva can harden, i.e. remineralise, the tooth enamel repeatedly through the presence of mineral substances. However, if demineralisation occurs too often due to frequent consumption of sugar-containing snacks, there is not enough time for natural remineralisation to occur. The balance between decalcification (demineralisation) and "repair" is disturbed – a hole in the tooth, caries, develops (Kassenzahnärztliche Bundesvereinigung, 2020). The Stephan curve (***Fig. 1***) illustrates this process very clearly.

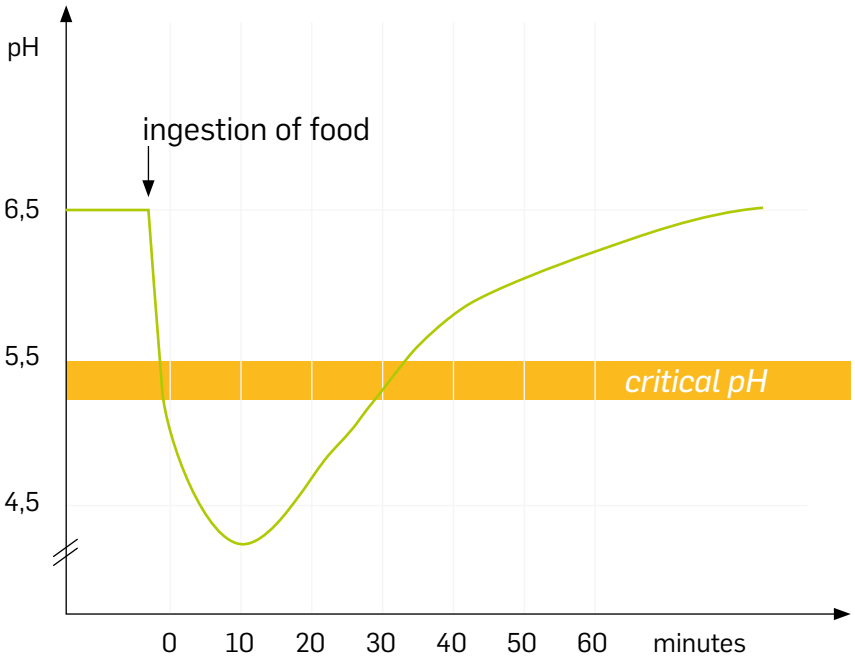

Fig. 1: The intraoral pH is lowered after ingestion of food by the conversion of sugars into acids by the bacterium Streptococcus mutans. Over time, the saliva neutralises the pH. The longer the acids have a chance to act, the faster caries develops. Modified according to Universitätsklinikum Gießen/Marburg.

Fig. 1: The intraoral pH is lowered after ingestion of food by the conversion of sugars into acids by the bacterium Streptococcus mutans. Over time, the saliva neutralises the pH. The longer the acids have a chance to act, the faster caries develops. Modified according to [Universitätsklinikum Gießen/Marburg].

The origins of caries

Oral colonisation with S. mutans often occurs within the first 31 months of life. It occurs through contact with caregivers' saliva, for example when they lick the baby's spoon, pacifier or bottle nipple (Berkowitz, 2006). Whereas it is often assumed that colonisation begins with the eruption of the first tooth, (Behrendt et al., 2002), some studies show that this can happen before tooth eruption in connection with maternal oral hygiene (Wan et al., 2001).

Interestingly, it seems that caries only became a problem in the last 8000–10000 years. As Dr. Brian Palmer (2000) noted in his anthropological studies, infants and toddlers were previously car-

ies-free. Furthermore, humans are the only species with early childhood caries – caries is unknown in more than 4640 mammals.

Can human milk cause caries? Indications from in-vitro studies

Human milk contains 7 % milk sugar (lactose), a substrate that S. mutans can break down into acids. Human milk is thus potentially cariogenic. But in addition to lactose, breast milk contains a complex mixture of nutrients, minerals, IgA antibodies, lactoferrin and hormones (Ballard, 2012). According to Velusamy (2016), lactoferrin is protective against S. mutans-induced caries. Furthermore, Rugg-Gunn et al (1985) report that S. mutans is less able to utilise lactose from human milk and thus convert it to acid than sucrose from breast milk substitutes.

Erickson and Mazhari (1999) show, among other things, the physical properties of human milk with regard how it affects plaque pH. Rinsing in human milk results in a drop in plaque pH to 6.4 compared to rinsing with water (pH 6.7). However, a 10 % sugar solution lowers the pH value more clearly into the acidic milieu – to 5.3. This suggests that human milk does not have a significant cariogenic effect. Furthermore, Erickson and Mazhari's experiments showed that under laboratory conditions, human milk did not cause demineralisation of the dental hard tissue even after 12 weeks of continuous exposure, whereas human milk mixed with 10 % sucrose solution caused caries after only 3.2 weeks. Compared to breast milk, sucrose-containing breast milk substitutes also promote bacterial growth (Ribeiro & Ribeiro, 2004). Thus, these in vitro studies conclude that breast milk alone has no significant caries-promoting effect.

Breastfeeding and caries – results from observational studies

There are numerous observational studies on the question of whether breastfeeding can favour the development of caries, as is often suspected. Interestingly, Tham et al (2015) and Cui et al (2017) in their meta-analysis of observational studies even report a protective effect of breastfeeding against caries in the first 12 months, compared to predominant breastfeeding and feeding with breast milk substitutes. In their reviews, however, they also report an increased caries risk in breastfed children after the first 12 months, especially in children who are breastfed at night or very frequently. However, they note that there is a lack of studies of children from the age of 12 months onwards that look at breast and bottle feeding, important factors such as the amount of sugar consumed in food and drink, and oral hygiene.

The most frequently cited study on early childhood caries by Peres et al. (2017 describes not only the protective effect of breastfeeding in the first 12 months, but above all the caries-promoting aspect of extended breastfeeding beyond the age of 2 years. In this Brazilian population-based birth cohort study, children who were breastfed for 24 months had a 2.4-fold higher risk of developing caries than those who were breastfed for only 12 months. There was no significant increase in risk between 13 and 24 months.

As I have already mentioned, these and other studies that examine the risk of tooth decay from the age of 12 months rarely control sufficiently for important influencing factors such as oral hygiene, timing, type and frequency of food intake and amount of sugary snacks, or for social factors. A systematic review by Moynihan et al. in 2019 concluded that breastfeeding up to the second birthday is unlikely to be associated with an increased risk of tooth decay, but that there might be an association after the second birthday. Additional, better controlled studies are needed to obtain certainty.

Devenish et al. recently (2020) reported in a cohort of Australian preschoolers that breastfeeding children to sleep at the breast at the age of one year is not associated with an increased risk of caries. In their study, however, they show clear connections between early childhood caries and socio-economic status. Due to the small number of children breastfed for more than 2 years in this study, additional, more significant results are needed. Other studies such as Menghini et al (2008), Baggio et al (2015) and Kraljevic et al (2017) also showed a strong correlation between low socio-economic status and caries risk as risk factors due to poorer access to dental care and parents' lack of knowledge about foods for healthy teeth and oral hygiene.

The necessity of adequate oral hygiene starting from the eruption of the first tooth is undisputed as a means of preventing early childhood caries. Experience has shown that if parents are well informed about oral hygiene, they will care for their children's teeth more consistently and thoroughly. In my personal experience, awareness of the importance of visiting the dentist regularly and meticulous brushing clearly depends on the role model function of parents, as Gläser-Ammann et al. (2014) have suggested. The (paediatric) dentist can advise parents about techniques and required items (toothbrush/toothpaste etc.) during the first visit to the dentist, which should take place around the time when the first tooth erupts if possible. In Germany, some states have developed an attachment to the booklet with the records of the child's medical check-ups (U-Heft) in which details of dental check-ups are recorded (e.g. the Berlin Kinder-Zahnpass).

Another factor associated with early childhood caries in many studies, including that of Devenish et al. was the intake of free sugar. According to the WHO guideline (2015) less than 10 % – ideally even less than 5 % – of energy requirements should be met by free sugars (added sugar in food, not present naturally). According to WHO data, the amount of sugar increases from 2 % of the daily energy intake that a 1-year-old child consumes on average to 38 % in a 2-year-old child.

In view of the extended WHO recommendation to meet only 5 % of the energy demand with free sugars, the limit is exceeded by 71 % in 2-year-olds and by 23 % in 1-year-olds. Free sugars are an avoidable risk factor.

The role of tongue dysfunction / oral restrictions

An important factor in the development of caries is the duration and frequency of exposure of the plaque-covered tooth surface to food or liquids. Prolonged contact with sugary foods and liquids, including breast milk, should be avoided at all costs. If we look at the mechanisms involved in effective breastfeeding, we find that the nipple is at the junction between the hard to the soft palate. The tip of the tongue remains in front of and above the inferior dental arch, covering it. The middle and rear parts of the tongue compress the nipple like a piston, thus emptying the breast (Elad, 2014). If this mechanism works physiologically, contact between the milk and the teeth is minimal. Breastfeeding at night (nutritive suckling) can therefore be seen as unproblematic.

If the flow of liquid in the oral cavity changes, e.g. due to tongue dysfunction or non-nutritive sucking while ›

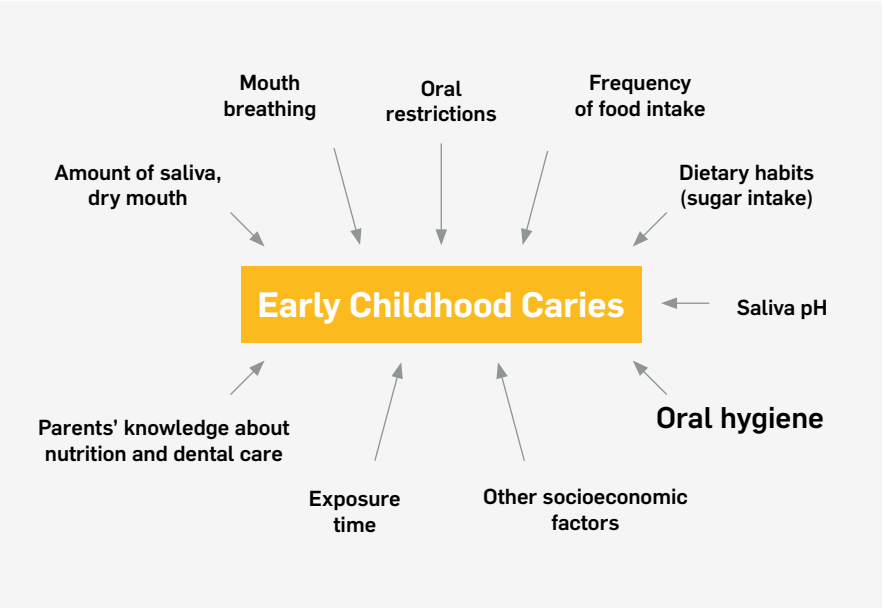

Fig. 2: Factors influencing the development of early child-hood caries.

› the baby is half-asleep, liquids have more intensive and frequent contact with the enamel surfaces of the teeth, which has a negative effect on the mouth pH and the ability of the enamel to remineralise, as described above.

Tongue dysfunction can be caused, for example, by structural or neurological impairments of the tongue or by oral restrictions. If a child does not suck physiologically and effectively, it is important to find out the reason for this to prevent caries. .

One possible cause can be a too short lingual or labial frenulum. Affected children have difficulty opening their mouths wide enough to take in a lot of breast tissue. Children with anterior tongue-tie cannot place the tongue over the mandibular gum pad and thus hold the nipple anteriorly and empty it posteriorly, with the result that the nipple lies more in the front part of the mouth. In the case of posterior tongue-tie, the emptying of the breast by specific movements in the middle and rear parts of the tongue is also restricted, with the result that the nipple also slips towards the front part of the mouth and the cheeks and lips reduce the size of the oral cavity to create a vacuum.

According to observations from my daily practice, which Dr. Kotlow also confirmed in a personal conversation, oral restrictions can have a caries-promoting effect.

Compensation for restrictions in tongue mobility may change the milk flow, with the result that the teeth have more contact with breast milk.

I have also observed that lip or buccal ties favour the development of caries. On the one hand, food and liquid residues can more easily remain under the tight lip, and on the other hand, dental care is considerably more difficult due to the lack of space under the tight lip and in the front of the mouth. In my opinion, more research is needed in this area.

Children with reduced tongue mobility, e.g. because of tongue-tie, often have difficulty draining the breast effectively (Garbin et al.2013). The small amount of milk they drink may shorten the intervals between feeds, which in turn affects the time it takes for the tooth enamel to remineralise and for the mouth pH to be neutralised.

Mouth breathing as a risk factor

Studies (Sharma, 2016 and Mizutani, 2015) show that mouth breathers have significantly more plaque on the tooth surfaces due to the dryness of the mouth and are therefore more prone to caries. Mouth breathing also alters salivation and intraoral pH. Generally, less saliva is produced during sleep and the pH is lower (approx. 7.3 during the day, about 7.0 during sleep) (Choi et al. 2016). Mouth breathing reduces intraoral pH during sleep even further to approx. 6.6.

Even without nighttime breastfeeding, these factors make remineralisation of the teeth significantly more inactive at night for mouth breathers. If nighttime breastfeeding is added as a component, with the changes in pH described above, this can lead to further demineralisation of the enamel.

Mouth breathing can occur habitually, due to nasal breathing restrictions (enlarged adenoids, allergies) or as a result of oral restrictions. Oral restrictions resulting from a too short lingual frenulum lead to an unphysiological tongue resting position in the lower jaw, resulting in an open mouth position, mouth breathing and a dry mouth. In a physiological resting position, the lips are gently closed and the front third of the tongue lies at the top of the palate. This creates slight negative pressure in the oral cavity, which can easily hold the tongue in this position, thus facilitating nasal breathing (Dieckmann, 2008).

Conclusion

In summary, current studies show that with adequate oral hygiene and a physiological sucking pattern in the first two years of life, there is no evidence of an increased risk of early childhood caries from breastfeeding.

So far, no study has been able to detect the complex relationships in the development of early childhood caries as a multifactorial disease (***Fig. 2***). Influences such as increased consumption of free sugars, restrictions in oral function, mouth breathing and socio-economic factors can favour the development of caries. Further research is needed to determine whether there is a cumulative effect.

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European Countries Are Failing to Protect the Health of Their Mothers and Babies, New Report Shows

Press release – 2nd June, 2020, Split, Croatia

World Breastfeeding Trends Initiative (WBTi)

The Covid-19 pandemic has shown how important it is for countries to protect their citizens from illness.

Babies who are breastfed have better health and resistance to infection, and most mothers want to breastfeed. Yet many European mothers stop or reduce breastfeeding in the early weeks and months, and bottle feeding is prevalent, due to inadequate support from health systems and society. The first European report on infant and young child feeding policies and practices compares 18 countries and identifies the considerable improvements they need to make in supporting mothers who want to breastfeed.

This new report, Are our babies off to a healthy start?, compares the implementation of WHO's Global Strategy for Infant and Young Child Feeding by the 18 European countries which have already assessed it. The comparisons show clearly that inadequate support and protection for breastfeeding mothers is a Europe-wide problem. The health of babies, mothers and whole populations loses out as a result. However, countries do differ considerably. Turkey rates highest overall; the five countries with the lowest scores belong to the European Union.

'Nutrition is key to achieving the Sustainable Development Goals related to health, education, sustainable development, reduction of inequalities and more.' (Joao Breda, Head, WHO European Office for Prevention and Control of Noncommunicable Diseases, Foreword)

The scope of the assessment is wide-ranging, with ten policy and programme indicators, including national leadership, hospital and community practices, marketing controls on breastmilk substitutes, health professional training, emergency preparedness and monitoring. There are also five feeding practices indicators, such as exclusive breastfeeding for 6 months, a WHO recommendation. The indicators with the poorest overall scores are national leadership and, shockingly, emergency preparedness. Yet the pandemic is an emergency for infants and young children and only North Macedonia was found to have an adequate strategy.

The original assessments were all carried out using the standard procedures of the World Breastfeeding Trends Initiative (WBTi), a tool first developed in 2004 by the International Baby Food Action Network (IBFAN) but only launched in Europe in 2015. It requires collaboration with relevant organisations within a country on assessment scores, gaps identified and recommendations for improvements. The Report highlights good practice, enabling countries to learn from one another.

'Success ...rests first and foremost on achieving political commitment at the highest level and assembling the indispensable human and financial resources.' (WHO Global Strategy 2003)

If governments, other policymakers, hospitals and community services, public health departments, institutions that train health professionals, and others, adopt the report recommendations, it will enable more mothers to initiate and continue breastfeeding, strengthening the health of the population for the future.

The WBTi European Working Group, led by Dr. Irena Zakarija-Grkovic of Croatia, produced the Report and comprises coordinators from European countries which have carried out a WBTi assessment.

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Summary of the Revised ABM Protocol #6 "Bedsharing and Breastfeeding"

Author: Elien Rouw

In this issue, we will present the eagerly awaited revision of ABM Clinical Protocol #6: Bedsharing and Breastfeeding, which was immediately translated into German by Denise Both. Bedsharing promotes breastfeeding initiation, duration and exclusivity. However, many health organizations advise against bedsharing as they believe it can increase the risk of sudden infant death. For this protocol, the ABM has enlisted some of the world's most renowned researchers in this field (Peter Blair, Helen Ball, James McKenna) who, together with specialists from the Academy, have revised the original protocol, published in 2011, on the basis of their own and other research findings. The recommendations in this protocol apply to mother–infant dyads in home settings, and are not intended for use in hospitals.

In this protocol, the history, context, and anthropology of the child's sleeping environment are discussed in detail. The protocol shows clearly that separate sleeping was only recommended in the late 19th and 20th centuries some in Western cultures. There is a detailed description of the concept of 'breastsleeping'. Here is a quote from the protocol: "Described in cultures around the world, the breastsleeping mother and infant feed frequently during the night while lying in bed together, and by morning, the mother may not recall how many times she fed or for how long." When nursing mothers sleep with their babies, they assume a typical sleeping position, the C-position, or 'protective C'. Infants who are 'breastsleeping' spend less time in deep sleep and more time in the lighter sleep stages, which can be a protective mechanism against sudden infant death.

Although some countries warn against sharing a bed with a (breastfed) infant, research shows that every single night, 20-25 % of infants share a bed with a parent for sleep for at least part of the night, especially if the baby is breastfed. There are many reasons for this. Many parents find that sleeping with their baby makes nighttime care easier. Research has also shown that bedsharing is associated with an increased breastfeeding rate. If the room is shared but not the bed, the breastfeeding rate, especially the duration of exclusive breastfeeding, is significantly reduced.

There is a detailed discussion of the epidemiological evidence on breastfeeding, bedsharing and SIDS risk, which includes the limitations in the statistical data of many studies. Breastfeeding was often not considered in larger studies. In addition, data on other risk factors, such as smoking and the intended sleeping place (safe or unsafe sleeping environment) was not collected, with the result that there is often a general warning against parents sleeping in one bed with their babies. However, so far there is no evidence to support the claim that sharing a bed with a breastfed infant increases the risk of sudden infant death in the absence of known risk factors. Deaths from suffocation are extremely rare in bedsharing breastfeeding infants. Moreover, the recommendation to sleep separately has negative consequences, such as the risks of early weaning, lower milk production and unintentional bedsharing in an unsafe sleeping environment (sofa, armchair).

For this reason, this protocol places great emphasis on the guidelines and strategies for minimizing risk and recommends that all families should be counselled about safe sleep. This should be in open discussions, first during pregnancy and then during infancy. Counselling should include the following questions:

- What are your plans for where your baby will sleep?
- What does that sleep area look like?
- Does your baby ever end up in bed with you?

Specific questions should also be asked about risk factors, such as whether the child was born prematurely, whether the parents smoked during pregnancy and postpartum, and whether alcohol or drug consumption by those living with the child and possibly sleeping together with the child is likely.

Even if risk factors are present and bedsharing is 'actually' discouraged, information and counselling on safe bedsharing should be provided, as it must be assumed that parents may sleep together with their child anyway, even if unintentionally. The most important risk factors, the elements of safe bedsharing advice and risk minimisation strategies are summarised in three clear tables on page 2.

This protocol helps to normalise bedsharing between breastfed infants and their mothers and thus makes an important contribution to the promotion of breastfeeding.

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› Blair PS, Ball HL, McKenna JJ, et.al. ABM Protocol # 6, Revision 2019: **Bedsharing and Breastfeeding.** Breastfeeding Medicine 15(1): 38-43, 2020, DOI: 10.1089/bfm.2019.29144. psb

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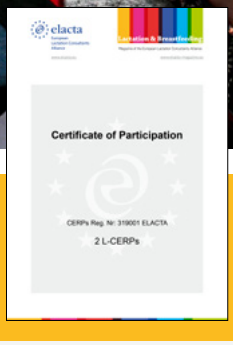

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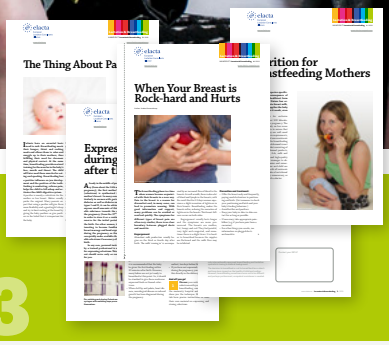

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