A SURVEY OF SATISFACTION OF POSTNATAL MOTHERS IN SHEFFIELD

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INTRODUCTION

Most midwifery and obstetric textbooks lead one to assume that once the baby is safely born, the mother is instantly able to cope with her new role. These textbooks discuss the physiological process of the puerperium, the nutritional needs of infant and the formation of the maternal- child relationship, but they give very few suggestions on how to help women cope with the varying demands and expectations which mothering involves.

Research on post-natal depression has investigated of the emotional trauma that women go through when they become mothers and the importance of peer and family support, but there appears to be very little literature on the special care and support that the health care professionals give during the post-natal period, and of the effect of this on the transition to motherhood. This is surprising when one considers that the medical professionals, particularly the midwives, have been supporting mothers through the childbearing process in all societies since the beginning of history!

Therefore the purpose of this research is three fold. Firstly, it is to learn more about the emotional needs of women as they take on the demanding role of motherhood. Secondly, it is to investigate the factors which may have psychological bearing on postnatal women and affect their emotional satisfaction. Finally, the role and influence of the health care professionals after the delivery will also be examined.

In the following paragraphs, four main areas will be discussed. They are: the choice of the place of childbirth, postnatal adaptation, maternal- child relationship and other factors influencing the psychological state of postnatal women.

LITERATURE REVIEW

PART ONE: THE PLACE OF GIVING BIRTH

That the place of birth should be a ' battlefield' for maternal choice is one of the more grotesque facets of the 20th century medical history. In 1958, obstetricians took care of 53 % of British births in hospital; by 1970 the figure had risen to 85%. Today it is reported that in most area, up to 99% of births take place in hospital. The paradox that home birth is safer is like the Emperor's New Clothes - it may be seen it you look but it took the skill and courage of one woman to proclaim this. Marjorie Tew (1990) pointed that " *The statistics prove hospital mortality rates are considerably higher for (both) high and low risk groups, outcome is significantly better at home, even for mothers with severe toxaemia. Low birth weight babies also prove to have a much greater chance of survival at home..... placenta praevia was the only indication where hospital birth would be safer.*" The only explanation Marjorie Tew can offer for the higher (mortality) rates for hospitals is the emotional upset many women feel about hospital as a place for giving birth.

As a result, in many parts of the country, choice has been narrowing rather than widening. Between 1980 and 1990 the number of isolated GP maternity units in the UK halved, from 212 to 106, while the number of units offering both GP and consultant care fell slightly, from 121 to 115. This might be interpreted as meaning that women preferred consultant care, but many of the closures were met with vociferous and concerted opposition from the users of the units.

In the recent report by the House of Commons Select Committee on Maternity Services more home births in British obstetric practice were advocated. (HMSO, 1992) This report received a frosty reception from the Royal College of Obstetricians and Gynaecologists, (RCOG, 1992) while the Royal College of Midwives and the other institutes welcomed its proposals. But the views of pregnant women have not been heard in this exchange of opinions. As Johnson (1992) surveyed, only 8% of 299 women at varying stages of pregnancy in ante natal clinics in two hospitals in Leeds stated that they would prefer to have their baby at home. The most commonly given reason for preferring a hospital birth was that skill and technology are available should unforeseen complications arise (50 %). This survey, however, being conducted in a hospital, cannot be considered entirely value free and, we must take into consideration that women's views may change as gestation progresses.

The British Medical Association's General Medical Service Committee estimated that up to 15 per cent of women might choose a home birth if they had the freedom to choose between a home birth and a hospital birth, and the committee proposed other major reforms in the maternity services. As a matter of fact, nowadays in the

Netherlands one -third of women give birth at home, with no increase in mortality or morbidity for mother or child. But not all groups are equally happy. Some midwives are concerned that home births might lead to greater danger for mothers, as they would not have instant access to high- tech facilities. The chairman of the British Medical Association's General Medical Services Committee felt that some of the proposals might eliminate the role of the family doctor. Consultants are among those who point out that the ideal solution would be to humanise the hospital environment but still have all births there for reasons of safety.

And Janet P (1992) suggested " *It is important that maternity units consider each individual woman's need for hospitalisation regardless of the support she perceives. Women must participate in the decision - making for discharge; if they are given appropriate access, information, resources and participation, they will make healthy choices for themselves and their families".*

PART TWO: POSTNATAL ADAPTATION

The postnatal period is a time of major adjustments as mothers adapt to new roles and new responsibilities. It is also a time when mothers appear particularly vulnerable to the opinions given and advice provided by health care professionals (Ball, 1981). Apart from recovering their physical well-being; the new mothers also need emotional support; information, a relaxed ward environment, teaching on infant-oriented skills and counselling (Laryea, 1982). Help and encouragement are also essential in the early days of motherhood, and the nurse or midwife should be able to anticipate and discuss problems.

However, care in the postnatal period has been found to be problematic. Filshie et al. (1981) found that institutional structures imposed on the postnatal mother mitigated against flexibility in relation to feeding. Meal times were set, for example, and the ward was too noisy for the patients to get adequate rest. Information provided by professionals lacked consistency and was often contradictory.

Tracy (1986) described from her study in Scotland, that, the main length of postnatal hospital stay was 4.6 days and over 80 % of the mothers were ' quite happy ' with that period of time when they left hospital. Ninety- six per cent of mothers were visited by a community midwife within 24 hours after they returned home and 83 % were seen by two or more midwives. Mothers who were interviewed felt that the number of midwives visiting reduced the possibility of continuity of care and could produce conflicting advice. The midwives gave mainly physical care (examination of abdomen or perineum, temperature taking), which was dictated by the time of discharge. Educational and psycho-social aspects of midwives' role (discussion of

baby care, feeding and family planning) were reported less frequently and did not always meet mothers' needs.

Also Lynette A (1990) pointed out that "Usual hospital practice is to encourage postnatal women to be independent on their first day after delivery. According to the results of current study, however, women are not ready to absorb the vast amount of information presented to them at that time because they are highly involved in the "taking - in" phenomenon.(defined the third to tenth day after child birth) Therefore, postnatal women should not be expected to learn how to look after their baby until at least 24 hours after delivery". And she suggested that nurses may need to re-examine their teaching role with postnatal women. Instead of attempting to teach these women in one day everything they need to know about caring for their new-borns, nurses need to relate the principles of teaching and learning to the time frames of puerperal change.

PART THREE : MOTHER- INFANT RELATIONSHIP

The significance of the maternal influence upon the early mother - infant relationship is generally recognised today (Ainsorth et al, 1978; Belsky, 1984; Vaughn et al., 1982). The relationship between maternal adjustment and infant development has been demonstrated in a number of studies (Lerner &Galambos, 1985; St James - Roberts, 1987)

In psychoanalytical literature, the transition to motherhood has been described as a normative intrapsychic process taking place mainly during pregnancy (Benedek, 1960; Kestenbreg, 1977). Transition to motherhood is described as a function of the woman's psychological reorientation and the physiological changes in her body. Earlier experiences of nurturing relationships are important in the psychological reorientation (Uddenberg & Hilsson 1974). Winnicott (1965; 1975) introduced the concept of "primary maternal preoccupation" for a state of normative heightened cognitive- emotional sensitivity, characterising the woman during the transition from pregnancy to motherhood. According to Winnicott, the functioning of the preoccupied pregnant woman is dominated by her inner psychic representations. In a study by Bohlin & Hagekull (1987) mothers identified by nurses at child health clinics as having problems with the mother - infant relationship, expressed a mental orientation less indicative of maternal preoccupation.

The mental pictures, or internal representation, that the woman constructs both of the infant and herself as a mother have been discussed as influencing maternal attitudes and behaviour after birth (Ammaniti et al.,1990). However, the discussion has focused more on the distorting characteristics of the internal representations than the longitudinal development of them.

In nursing research, the attainment of the maternal role has been identified as an interactive process in which the mother achieves a new behavioural competence (Mercer, 1985; Walker et al.,1986). The core- self of the woman is extended to a maternal- self (Robin, 1967) and the mother gradually identifies herself as a mother to this particular child (Walker, 1986). Belsky (1984) has focused on how the integration of maternal behaviour is dependent on the intra psychic state of the woman as well as the infant's status and their environment.

In UK the reported incidence of postpartum depression has ranged from 5 per cent to 22 per cent (Richards J P, 1990). Postpartum depression not only may have devastating effects on mothers, but also may have adverse consequence on young children's general behavioural and developmental functioning (Fleming et al.,1988; Whiffen & Gotlib, 1989). Holden (1991) described that by advocating the need for early identification of women needing emotional support and early intervention rates of postpartum depression could be reduced.(Holden J M, 1991)

One study showed that extra social support during pregnancy might significantly enhance the experience of motherhood over the first year of the child's life. (Oakley A, 1992)

In comparison to married mothers, single mothers have been found to be more socially isolated, receiving less emotional and parental support, and having less stable social networks (Weinraub & Wolfe, 1983). Some researchers, found significant positive relationships between social support and health conditions of the new mothers (e.g. Hall, Schaefer, & Greenberg, 1987). There was also evidence suggesting that the beneficial effects of social supports depended more on the quality rather than the quantity of social ties (Hall, 1987). Family support and a close relationship with an initiate or confidant (Brown et al,1975) being important to the mental health of women.

PART FOUR: OTHER INFLUENCING FACTORS

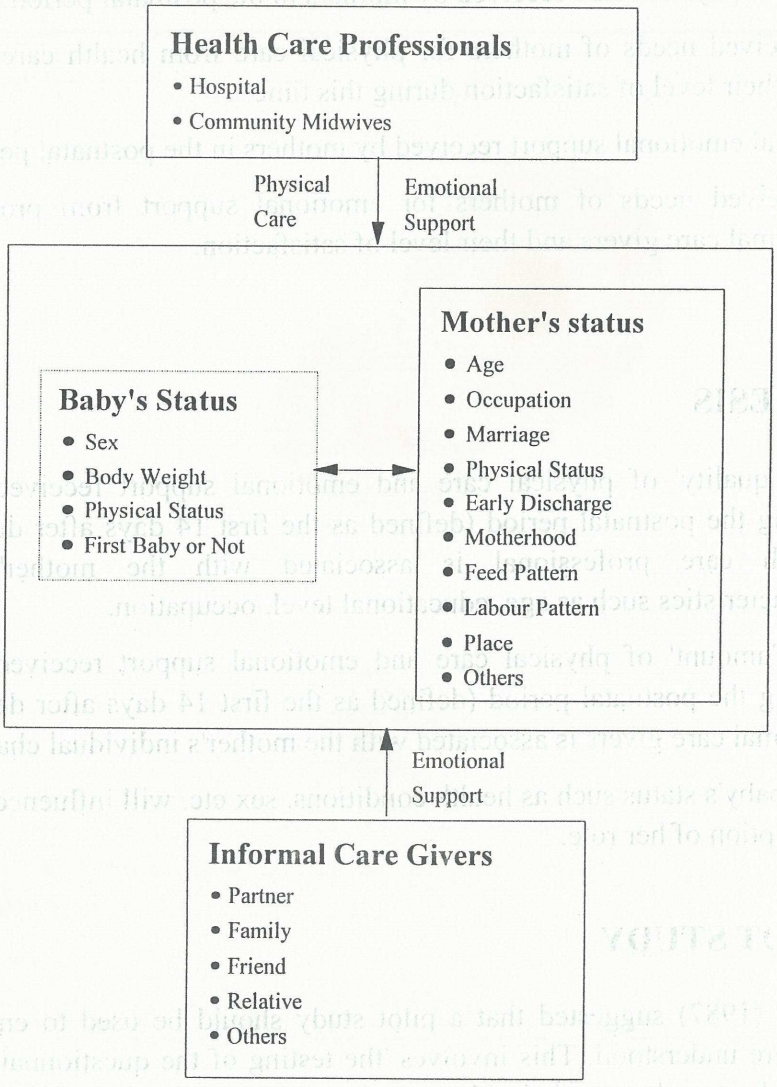
There are many factors which have psychological bearing on postnatal women. Some studies showed that (Avery, Fournier, Jones & Sipovic, 1982; Lemmer, 1986) early postpartum discharge was a safe, satisfying, and cheaper alternative to the customary length of hospital stay for low- risk mothers and their babies. However, the studies of the past decade evaluated the physical safety of mothers discharged early and not their psychological safety.One study indicated that women in the experimental group (hospital discharge 24- 48 hours) felt more tired than control group (hospital postnatal stay of 6 days). Seventy per cent of women in both groups reported fearfulness during the first 2 postnatal weeks, with the peak of fear on the fourth to the fifth after the birth.(Arborelius E, 1989)

There was also a significant relationship between depression and indicators of deprivation, e.g. low income, overcrowding, etc. (Oakley, 1991) English studies showed that symptoms of postpartum "blues" peak on days 3 through 7 following delivery. Studies on African women have shown a pattern similar to the one described for English women. However, the incidence of the "blues" has not been systematically studied in American women who are discharged from the hospital 24- 72 hours postpartum. The purpose of this exploratory study was to examine maternal mood patterns for the first 14 days after delivery. (York R, 1990) Also this study found that a combination of many factors influence the life of the new mother and might result in a high level of dispression. Women were reluctant to share the negative side of pregnancy and motherhood with other women, lest they are deemed incompetent. Finally, the new mother was usually called upon to fulfil the dependency needs of many people, including those of her husband. The study suggested that much could be done to alleviate these stresses by providing safe communal play areas, good child care facilities, and self help and social support groups for parents. (Dwenda K, 1991)

Depression still affects 5-22% of women after childbirth (Richards JP,1990) among the factors known to be associated with postnatal emotional disturbances are anxiety and low self- esteem in the mother, marital tension, conflicts within the family and life crisis events occurring during the same period as the birth of the baby (Kumar & Robson, 1984) So the midwife's role is particularly important in the early recognition of puerperal psychosis and for identifying mothers at high risk.(Cox, 1986).

The following survey has been designed to investigate the relationship between the postnatal mothers' perceived needs and experience of their care by health professionals and significant others.

Figure 1 Operationalisation of Concepts



ETHODOLOGY

AIMS

The aims of this dissertation are to investigate the following:

1. Actual physical care received by mothers in the postnatal period.
2. Perceived needs of mothers for physical care from health care professionals and their level of satisfaction during this time.
3. Actual emotional support received by mothers in the postnatal period.
4. Perceived needs of mothers for emotional support from professional and informal care givers and their level of satisfaction.

HYPOTHESIS

1. The 'quality' of physical care and emotional support received by mothers during the postnatal period (defined as the first 14 days after delivery.) from health care professional is associated with the mother's individual characteristics such as age, educational level, occupation.
2. The 'amount' of physical care and emotional support received by mothers during the postnatal period (defined as the first 14 days after delivery.) from informal care givers is associated with the mother's individual characteristics.
3. The baby's status such as health conditions, sex etc. will influence the mother's perception of her role.

THE PILOT STUDY

Oyster et al, (1987) suggested that a pilot study should be used to ensure that the questions were understood. This involves 'the testing of the questionnaire on several individuals who are characteristic (but not the same as) of the population of interest'. Cormack (1984) also stated that 'a pilot study is vital for working out weaknesses and thus improving the measuring capacity of the questionnaire'. For this research one pilot study was carried out. Four postnatal period mothers were requested to complete the questionnaire and then it was discussed informally. the constructive criticism that they gave, led to an adaptation of the layout of the questionnaire.

COLLECTING THE DATA

By joining community midwives team during their home visit thirty-four posnatal mothers were visited during the period from 7th April 1993 to 20th May 1993. Each of them was given a questionnaire to fill in. A total of twenty-four questionnaires were returned. The population in the sample was largely social class II, age ranging from eighteen to thirty-seven, with ninety-five percent being British. The non-responders were equivalent in age and social class.

ANALYSIS

During the design of the questionnaire, coding, post coding and analysis were considered. For open-ended questions , all the responses were reviewed and evaluated before coding was done. Full explanation and description were then presented. (Details in appendix)

For closed questions, the coded data was analysed using the SPSS package. The analysis of the variables is based on significance difference testing procedure. A p value of less than 0.05 is conventionally taken as evidence of general differences between some of the population means, the smaller the p value the stronger the evidence for differences.

DEFINITION OF TERMS

The term used in this study are defined as follows:

MOTHER:

Mother is the woman who gave birth to you and there is usually a strong relationship between mother and child. In this study 'mother' means those who had given birth to the baby within fourteen days from the date of the questionnaire.

SATISFACTION:

A feeling of contentment on the part of the mother with the care that has been received.

HEALTH CARE PROFESSIONAL:

Those who offer postnatal health services to mothers including GP, midwives, nurses, and doctors in the hospitals and community midwives.

INFORMAL CARE GIVERS:

Partner, family, friends, relatives, parents and others who give support to the postal

women.

MOTHERHOOD:

The mother's perception of her role.

DISCUSSION OF RESULTS

An obvious limitation of this study is the small number of cases in the sample. Therefore conclusions have to be drawn cautiously.

This section will examine in detail the answers in the questionnaires in relation to the research which has already been carried out as presented earlier. The discussion will be divided into four sections each corresponding to a different area identified in the questionnaire.

The five areas to be examined are:

1. Mothers' satisfaction with care.
2. Actual emotional support received by mothers in the postnatal period.
3. Mother's perception of her role
4. Choice of birth place
5. Improving the postnatal care

MOTHERS' SATISFACTION WITH CARE

An important theme which runs through both quantitative and qualitative questions concerns the assessment of the extent to which the health care professionals could satisfy the mothers' perceived needs and quality of their service, the analysis in the earlier section has compared the level of hospital services provided with the variation in mothers' particulars such as age, education level, marital status etc. However, no statistically significant relationship could be found between the mother's individual characteristics and the hospital health care received. The small sample may have limited the result. On the other hand, from the mothers' comments in the open -ended questions it was found that:

The chief reason for the mothers to choose delivery in hospital was "safety". They felt safer giving birth in hospital particularly if there were any complications. Also, the mothers stated that they could get more rest in the hospital. Similar observations were made in Johnson's (1992) study. A total of 299 women were asked where they would prefer their baby to be born and why. One of their answers was that they preferred to deliver in hospital because of the small risk of complications during labour.

A set of questions in the questionnaire invited the mothers to record their overall satisfaction with the main elements of the care provided. Seven areas of service were assessed (each in a different question). The answers reflected the mother's evaluation

of the health care they received from the hospital. The possible range of scores was from 7 to 35, and the actual range of scores recorded by the mothers was from 11.0 to 35.0, with a mean of 27.5 and a standard deviation of 5.9. This average score indicates very positive evaluation of emotional support offered by hospital staff. The result is similar to Val Mason's (1989) finding in her " Women's experience of maternity care- a survey manual . In that study a sample size of between 300 to 400 women was used their and overall satisfaction with the main elements of their care were recorded. Approximately 31 % of women were satisfied in some ways but not in others, while two thirds of the women were satisfied overall with the health care that they received.

Another set of questions was used to assess how far the mothers were satisfied with the health care provided by the community midwives. Nine areas or services were assessed (each in a different question). The answers reflected the mothers' evaluation of the quality of service. The possible range of scores was from 9 to 45, and the actual range of scores recorded by mothers were from 30.0 to 45.0, with a mean value of 38.8 and a standard deviation of 4.6. The result showed that the mothers were also generally highly satisfied with the community midwives' service.

ACTUAL EMOTIONAL SUPPORT RECEIVED BY MOTHERS IN THE POSTNATAL PERIOD

One set of questions was designed to ask the mothers about the emotional support provided by their partners , friends, relatives or family. There were four questions, the minimum score was 4 and the maximum score was 20. The actual range of scores recorded were from 11.0 to 20.0, with a mean of 16.1 and a standard deviation of 2.6. J Ball (1987) in her survey describes that the supportive environment which surrounds mothers is composed of the help they receive family and friends, and the help provided by society in the form of maternity and social services. The effectiveness of the support will depend upon the degree of understanding provided by health care professionals . Unterman (1990) also suggested that social support could help to improve recognition and management of the women at risk of developing postnatal depression.

Five areas were examined when assessing the mothers' total emotional satisfaction. They were support from hospital, community midwives' team ,informal care givers, family and the mothers own self confidence and satisfaction with her motherhood. The total score of postnatal period mothers' satisfaction, therefore, was the sum of scores of these five areas. The range of scores recorded was from 86 to 123, with a mean of 103.8 and a standard deviation of 11.5, implying a high degree of satisfaction with the emotional care provided from all sources.

MOTHER'S PERCEPTION OF HER ROLE

There was also a set of questions that dealt with the attitudes of women towards their role as mothers. Several questions were used to assess a woman's feelings towards her baby. Although no statistically significant association could be found between the mother's attitudes to her baby and the baby's condition, it was observed that satisfaction with motherhood acted as a boost to a woman's emotional well- being. This was manifested in the mothers' reported feelings of joy and contentment after the birth. However, from the mothers' comments, it appears that the mothers needed more information about looking after the new baby. They also need more encouragement, so that they could build up their confidence to cope with the changes in their lives. The relationships between midwives and mothers, and their partners if present, are usually very close because they share the experience of labour and delivery together. Even if the midwife does not conduct the delivery, she is the one who cares for the mother and her baby immediately afterwards. Midwives are therefore in a good position to enhance the relationship between the mother and her baby during the postnatal period, by encouraging the mother to take care of her baby, to feed him or her and to enjoy being with him (or her). This is particularly important when the mother appears to be indifferent towards her baby. Midwives can usually identify mothers who are experiencing distress, and it is therefore possible for their perceptions to be harnessed for the mothers' benefit. Under such circumstances, it may be necessary for the midwife to spend a longer time with the mother in order to encourage her to respond to her baby (J Ball 1987) .It can be seen that the mothers' degree of satisfaction with community midwives is high in the present study.
Reva Rubin (1984) states that when a woman is feeding her baby she is not just giving food, but she is also communicating her love and protection. She is rewarded and encouraged when the baby receives the food eagerly and blooms from her efforts. It is therefore extremely important for the mother to be confident that her baby is receiving the care that he needs, and to feel that she is the key person who is able to fulfil those needs. This confidence takes time to develop, and will depend upon the care and encouragement the mother receives. The over-riding principle in helping mothers to gain this confidence is encouragement and praise. The midwife is in a particularly good position to provide this.

The mother's perception of her feeding and her satisfaction with motherhood are linked. Because her perception of feeding is one of the most important factors affecting emotional well-being, this factor is the most amenable to change.
In this study it can be seen that the breast feeding mothers benefited from this process. They received a good deal of help and encouragement from midwives. Successful breast feeding reinforced the mother's role as a key person, indeed the only person, who could fulfil her baby's needs.

The bottle feeding mothers, on the other hand, did not receive as much attention. They were not given as much encouragement and praise for their skill in providing for their babies' needs. This might be the reason why their satisfaction was much lower than that of the breast feeding mothers.

Helping mothers to become confident, and identifying those who need to take things slowly and steadily, can only be achieved in a programme and pattern of care which focuses upon the needs of individual mothers and allows them the freedom to be different. A uniform programme which does not cater for individual needs will be as frustrating for confident mothers who do well, as for the mothers who are having problems.

CHOICE OF BIRTH PLACE

The majority of mothers are transferred to the care of community midwife two or three days after the birth of their babies. The bulk of postnatal care therefore takes place in the community. Although the pattern of early return to home has been typical of maternity care for a number of years, the continuation of community care after the tenth postnatal day is a comparatively recent development. However, in this study, the maternity care provided in Sheffield usually continues until the twenty- eighth postnatal day. The community midwives pay home visits to the postnatal mothers everyday till the tenth after delivery day. From then on depending on individual needs, they either visit or phone the mothers. However, all the postnatal mothers in this study filled in the questionnaires within 14 days of delivery. Therefore their answers could only cover their feelings towards, and evaluation of the first half of the care provided. If an assessment of the full 28 day postnatal care is required, a more detailed survey may have to be carried out in future.

Usually after child birth, a mother needs time to rest and recover from the physical stress of labour and delivery before she embarks upon the process of coping with all the demands which motherhood brings. For the majority of women this process will begin in the postnatal ward of a hospital. Many women prefer to go home as soon as possible after delivery. This is because they have had a normal labour and delivery and feel confident that they have the kind of help and support at home which will enable them to cope with the demands from the baby. However, a small number of postnatal women need to stay longer in order to recover from a difficult pregnancy, labour or delivery, or because the baby is in need of special care. There are also some who prefer to stay longer because they need time to become confident in feeding and caring for their baby, or because they lack help at home. Therefore, a woman should be allowed to determine the length of her stay in hospital according to her confidence

in caring for her baby, and the amount of help she can expect to receive when she goes home. From the study, it would appear that mothers' level of satisfaction with the hospital health care service has little relationship with the length of stay.
Recording the mothers' comments on the hospital service, one mother felt that some of routines in hospital were unreasonable, and she was also quite upset by the " bad attitudes" of some of the staff. Some mothers commented that they felt lonely staying in hospital, and they didn't like the monitor's noise. On the other hand, several mothers stated that they could get more rest in the hospital. It should be noted that mothers can get more rest in hospital if the disturbance e.g. crying babies at night, can be reduced, and also by allowing mothers to rest during day time.

IMPROVING THE POSTNATAL CARE

The analysis so far has examined the ways in which postnatal care could be enhanced in order to improve the emotional well - being of postnatal mothers. This section will look at factors related to woman's feelings towards her baby and her confidence as a mother.
The purpose of all maternity care is to enable a woman to be successful in becoming a mother. This not only applies the physiological processes involved but also the psychological and emotional processes which motivate the desire for parenthood and its fulfilment.
Successful pregnancy leads inevitably to labour and birth, and to the joys and responsibilities of parenthood. However much parenthood is sought and welcomed, it is a irrevocable process which brings tremendous physical and psychological change within a comparatively short period of time and it makes great demands upon a woman's emotional and psychological resources. The birth of the baby marks the watershed of those changes, and it is during this time that mothers are most in need of caring and sensitive support from their families and friend. It is also during this period that the attitudes and caring skills of midwives and doctors have the most impact.
Childbirth and mothering should be a time of fulfilment and joy for both mothers and fathers, and the quality of the care which surrounds them should be a matter of concern for the whole of our society.
There have been many changes in the last twenty years, one of the most fundamental being the transference of the place of delivery from home to the hospital. This marks a major change in the cultural patterns of childbirth in the West, and in the physical and psychological environment in which mothers and babies begin their lives together. The family to which they both belong is fragmented during this critical phase in their lives, with the mother and baby in hospital and the father, siblings and grandparents at home.

It is unfortunate that little attention by society is usually paid to the mother during the postnatal period, because it is during this time that the mother, her partner and their baby learn to care for one another, and establish, to a substantial degree, the pattern of their relationship with each other in future. An unhappy woman will not able to take up her role as mother successfully. She will feel that she is failing both her partner and her baby. Her self - image will be impaired, family relationships will be strained, and an experience which should be joyful and fulfilling may instead become one of frustration and disappointment.

The objectives of postnatal care are threefold and inter- related. They are: promoting the physical recovery of the mother and baby from the effects of pregnancy, labour and delivery; establishing sound infant feeding practices and fostering good maternal - child relationship; providing the psychological support required to strengthen the mother's confidence in herself, and in her ability to care for her baby, whatever her particular personal, family or social situation may be.

The role of health care professionals who care for mothers, fathers and infants during the first days and weeks following childbirth should be centred upon nurturing the mother in such a way that she is able to adjust to the major changes which the baby has brought into her life, to become confident in caring for her baby, and to enjoy her developing relationship with the baby (Curry 1982). From this firm emotional base she will then be able to respond to the needs of her partner and family. In this way such relationships will be strengthened enabling all the members of the family to give and receive the loving support which each one needs from the others.

It is important that all health care professionals involved with the care of mothers and babies should resist the tendency to be defensive about their respective roles and stifle their eagerness to apportion blame for problems which arise. Instead, they need to develop a willingness to listen and learn from each other and from their "clients". They should learn to recognise that facing and overcoming problems and criticisms is necessary for those who seek to maintain the highest standards of service and integrity.

CONCLUSION

In summary, becoming a mother is a developmental process which takes place continuously through constant interaction with the child and environment. Reva Rubin stated that " the woman in her immediate postpartum period undergoes phenomenal physical and psychological changes to which greater attention could well be given." In this survey, the questionnaires were answered within 14 days of the delivery. Under Rubin's term, mothers in the study would have started to actively take up their maternal duties in an independent manner. Therefore, they were beginning to feel more responsible for their babies. At the same time they were getting more satisfaction from their role as a mother. However, from the present study, it was

observed that some mothers felt the physical toll of looking after a baby and complained of lack of sleep and insufficient rest.

"The maternity role adaptation is tapping into the intrapsychic state of the woman, reflecting her earlier dreams and inner representations of the situation. When the mother gradually faces the practical demands of care giving, her internal representations becomes intertwined with the reality- based needs of the infant, as well as the demands of the environment". This is in agreement with discussions by Walker (1986), which emphasised that the maternal role activities during the infant's first months are basically dominated by the dependent nature of the infant.

The health care service should be more flexible to allow the care of women with complications to be shared between a community group practice and a hospital team if this seems the most desirable alternative. At present , for a woman who is transferred to the hospital in the late stage of pregnancy, it is most likely that her postnatal care will return to the community group practice. As stated earlier, a flexible approach to sharing of care can be adopted to suit individual circumstances.In these cases, the hospital and community midwives should maintain close co- ordination with each other in order to provide continual care to the women. In addition, midwives and medical staff should each recognise the special skills of the other and come to decisions with the full participation of the women and their partners to the satisfaction of all concerned.

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