

EXPLORING THE SUBCONCEPTS OF THE WITTMANN-PRICE THEORY OF
EMANCIPATED DECISION-MAKING IN WOMEN'S HEALTH CARE
USING INFANT FEEDING METHOD AS THE CLINICAL EXEMPLAR

A Dissertation

Presented to the Faculty of the

School of Nursing

Widener University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Nursing Science

By

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School of Nursing

May, 2006


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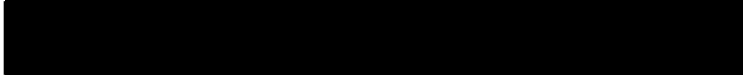


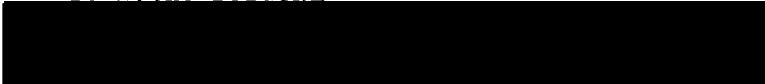
Title of Dissertation: Exploring the Subconcepts of the Wittmann-Price Theory of Emancipated Decision-Making in Women's Health Care Using Infant Feeding Method as a Clinical Exemplar


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This dissertation is dedicated to my brother-in-law

Denis McDowell

who is teaching us all a new form of bravery.

ACKNOWLEDGEMENT

I would like to thank my husband, David Price and children Rachel, Samuel and Rosemary for having patience with me during my doctoral studies. Thank you to my sisters, Judy, Eileen, Janet and Mary, for proofreading and support, and my niece Mary for helping with the figure. Thank you to my mother and father for their support.

I would like to thank Deans Mary B. Walker and Marguerite Barbieri for their encouragement, Dr Barbara Patterson for her advisement, recommendations and reading, Dr. Lynn Kelly for reading and Mrs. Betty Boyles for always being pleasant in the nursing office and keeping me organized.

Also I would like to thank my committee members for their endless hours of work. Dr. Anne Krouse and Dr. Lynne Borucki, thank you for reading, editing and rereading. Most of all I would like to thank Dr. Lois R. Allen for believing in me and my ideas. I couldn't have done it without you!

Lastly, I would like to thank Carol Kuplen and the nursing staff of PPHP3 at St. Luke's Hospital and Health Network, for encouraging and supporting nursing research.

ABSTRACT

The Wittmann-Price Theory of Emancipated Decision-making (EDM) was derived from the philosophical underpinnings of Critical Social, Freire's Emancipatory Education and Feminist Theory. The theory describes a process of reaching a more positive state of being, a state of freedom in choice, by first acknowledging the affective experience of oppression in women's healthcare. This oppression produces a dilemma in decision-making by socially sanctioning one alternative as superior over all other alternatives. The theory proposed that five subconcepts must be present when using the decision-making process. These are empowerment, a flexible environment, personal knowledge, reflection, and social norms. This study used three instruments, Subject Demographic Questionnaire (SDQ), the Wittmann-Price Emancipated Decision-making Scale (EDMS), and the Satisfaction with Decision scale (SWD) by Holmes-Rovner (1996) to collect data from 97 women who delivered uncompromised term infants in one Pennsylvania hospital. Pearson correlations showed all EDMS subscale intercorrelations were significant except for the relationship between reflection and personal knowledge and between reflection and social norms. The hypothesis that emancipated decision-making leads to satisfaction with the decision was supported. Correlation of EDMS and SWD scores yielded a $r = .74$ ($p < .001$). The linear combination of the EDMS subscales of emancipated decision-making predicted satisfaction with decision-making better than any one element alone. The combination of personal knowledge and flexible environment was the best predictor of satisfaction and explained 62.2% of the variance. Additional analyses of data revealed positive correlations between employment and empowerment

and negative correlations between age, parity and empowerment as well as a negative correlation between parity and reflection. This study was done as the first part of the ongoing theoretical development of the Wittmann-Price Theory of EDM.

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CHAPTER 1

INTRODUCTION

Decisional science in healthcare is an important area of study because today consumers have more information available to them than ever before, producing more options with more information to incorporate into their healthcare decisions. This is reflected in the comment of Pierce and Hicks (2001), "Given the ubiquitous nature of human decision-making and the nature of the current healthcare environment, it is imperative to further develop this knowledge and integrate it into clinical care" (p. 267).

Decisional science in healthcare, related specifically to women, lacks development (Button, 1999) and the building of decisional science from a nursing perspective has lagged behind that of other disciplines (Noone, 2002). Due to natural developmental events in a woman's life which can alter health status in a fairly short amount of time, such as childbirth and menopause, making healthcare decisions becomes important for continued well being throughout the lifespan (Andrist, 1998; Brown, Carroll, Boon & Marmoreo, 2002). Therefore, a woman's decision-making about her healthcare options is a significant nursing concern. The fact that women make the majority of healthcare decisions for their family members also supports the need for further development of decisional science in women's health (O'Connor, Jacobson & Stacey, 2002).

Current decision-making frameworks and research about women's healthcare options have developed within the social norms of the established healthcare system. The healthcare system in the United States was developed with strong paternalistic influences

and still fosters oppression towards women. Decisional science has not addressed the impact of underlying oppressive social norms and how they may affect women who are making healthcare choices. This study assumes that social norms within the healthcare system can be sufficiently oppressive and have the capability of impeding women's freedom of choice in decision-making about healthcare issues (Arslanian-Engoren, 2002; Holmes, 2002). This study upholds that the phenomenon of oppression is very much present and recognizable in women's healthcare. The phenomenon of oppression impacts women's decision-making about healthcare options and often motivates women to choose the most socially-accepted healthcare alternatives rather than the alternatives that are best for them personally.

This researcher has developed a theory of emancipated decision-making and proposes that women who choose healthcare options which suit their preference or life style, regardless of whether or not the chosen alternative is the most socially encouraged, have made a more positive or satisfying decision. This researcher posits that women who make emancipated decisions are more satisfied with their decisions. Women who choose the most socially acceptable healthcare options knowingly, when those options do not fit their preference or life style, have not made an emancipated decision and may be dissatisfied with the decision (Wittmann-Price, 2004).

The topic of exploration for this study was the concept of emancipated decision-making in women's healthcare. In order for a woman to make emancipated decisions, specific subconcepts must exist. This researcher proposed that those subconcepts are empowerment as a result of being given information by professionals; flexible

environment provided by non judgmental nursing care; personal knowledge or the woman's ability to know what is innately best for her; reflection, as defined as the woman having thought about or considered all the choices presented to her and their consequences; and social norms, or what is verbally and non verbally, consciously or unconsciously transmitted to the woman as the most acceptable choice.

By studying one specific women's health issue, the choice of infant feeding method, the concept of emancipated decision-making was better explored. Infant feeding method was chosen because all three popular choices are acceptable. The three choices most used as an infant feeding method are breastfeeding, bottle feeding or combination feeding (breastfeeding with bottle feeding supplementation with formula or breast milk). Infant feeding method is a significant healthcare decision because it affects a woman personally as well as her lifestyle (Rodriquez-Garcia, 1990). Also, infant feeding method is a priority in women's health and has generated social awareness, spurring a great amount of research (Healthy People 2010).

Background

The oppressive issues in healthcare that impose decisional dilemmas on women have differed over the years; but, the characteristics of the phenomenon have been consistent, thereby producing a subtle but recognizable pattern. Since oppression is deeply embedded in society, and therefore healthcare, the pattern may not always be easy to recognize to the casual observer. Nurses, who are in a profession comprised predominantly of women, may lack objectivity in recognizing the phenomenon of oppression in healthcare because they are part of the same oppressive system (Kessler-

Harris, 1981; Novarra, 1980). Therefore, studies recognizing oppression may increase awareness of nurses of its presence and effect within the healthcare system.

Clinical Observation

Oppression of women in healthcare decision-making is discussed from a contemporary and a historical point of view in the theoretical development of the Wittmann-Price Theory of Emancipated Decision-making (EDM). This study assumed that oppression of women still exists in society and healthcare. This assumption is the culmination of years of observation and reflection from direct clinical practice. This researcher has witnessed oppressive environments within hospitals that apply pressure to some women to arrive at the decision that best suits the healthcare system, or provider, or conforms to the current healthcare trend. The following are a few brief examples observed in clinical practice.

Twenty-four-hour rooming in has become the standard in family-centered care (Troy, 2003). In many cases the woman is happy to be with her infant in a private room but has an overwhelming need to sleep after her delivery. The hospital has promoted rooming-in by restructuring the physical space to accommodate an infant crib in the room and removing the large type central nursery. Many hospitals also advertise rooming-in as a favorable consumer option. All these factors pressure the woman to believe that sending her infant to a central nursery to be observed between feedings, to promote her own rest, is socially discouraged.

Another recent example of possible oppression this researcher has observed in the clinical area is that of family-centered care. Family-centered care was promoted in the

1970's to increase partner involvement in the childbirth experience (Zwelling, 2000).

This philosophy has matured to including the woman's partner in all aspects of childbirth including lodging and meals. The presence of another person whose opinions about childcare and child rearing differ from the woman's at times presents an oppressive situation. Decisions may be based on the opinion of the partner because the woman lacks either self confidence or energy to present her argument.

In the recent past, another observed oppression in women's healthcare choice was that of pain management during childbirth (Cook & Wilcox, 1997). During the era when natural childbirth was socially popular, many women chose not to receive anesthesia due to the fact that childbirth without medication was not only promoted but to some extent honored as a womanly feat.

These examples are just a few of the types of oppressive situations which affect women's decision-making about healthcare issues on an individual and social level. This study focuses on the oppression that affects women on an individual level but acknowledges that women as a group are oppressed. Historical examples that demonstrate oppression of women in healthcare on a social level are discussed in Chapter 2.

The Wittmann-Price Theory of EDM is a practice theory for nursing, developed by this researcher, to explain decision-making in the context of women's health. The Wittmann-Price Theory of EDM recognizes that oppression continues to exist and is imposed by society for purposes of situational control (Barrowclough, 1997; Rapley, 2002). The Wittmann-Price Theory of EDM assumes that social norms affect the

decisions women make about their healthcare and that values imposed by society have the potential of curtailing women's free choice in healthcare options. The development of the Wittmann-Price Theory of EDM is philosophically grounded in Critical Social (Avineri, 1972; Duchscher, 2000; Marx & Engels, 1976), Feminist (Gornick, 1978; Hubbard, 1995; Perry, 1994) and Freire's Emancipatory Education (Freire, 1970; 1992; 1998) theories. The Wittmann-Price Theory of EDM describes a positive process for women faced with healthcare decisions and contains identifiable subconcepts. The subconcepts of an emancipated decision have been synthesized from an extensive review of the literature and this researcher's clinical practice. The identifiable subconcepts are empowerment, flexible environment, personal knowledge, reflection and social norms. These five subconcepts and their relationships to an emancipated decision-making process are depicted in Figure 1. One proposed measurable outcome of an emancipated decision is satisfaction with the decision, the outcome variable measured in this study.

Assumptions of the Study

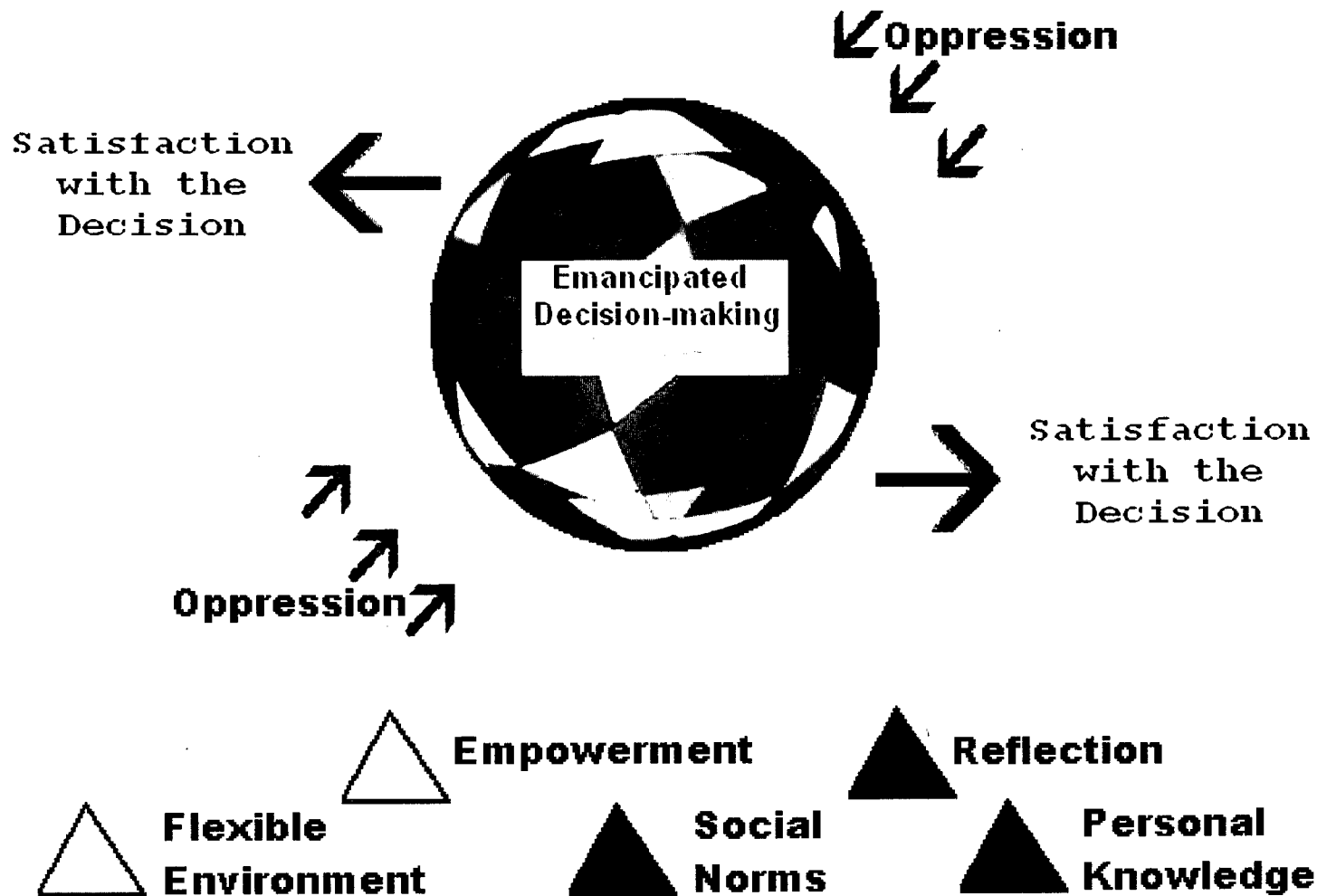
This study was predicated on the following assumptions:

1. Infant feeding method is a significant healthcare decision for women.
2. Infant feeding method represents a decision that is influenced by social norms.

Purposes of the Study

The primary purpose of this study was to test the subconcepts of an emancipated decision-making process in women's healthcare, using women's choice of infant feeding method as the clinical exemplar. The secondary purpose was to explore the relationship

The Wittmann-Price Emancipated Decision-making Theory in Women's Healthcare



of emancipated decision-making and satisfaction with the decision. Emancipated decision-making in women's healthcare is a theoretical concept grounded in history, explained by Critical Social, Feminist, and Freire's Emancipatory Education theories and described through an extensive review of the literature and observed in this researcher's clinical practice. This study was conducted to test and refine subconcepts in the ongoing theoretical development of the Wittmann-Price Theory of EDM.

Research Questions

The primary purpose of this study was addressed by the following research questions:

1. What are women's scores on total emancipated decision-making and the five subconcepts of emancipated decision-making?
2. What are the relationships among the five subconcepts of emancipated decision-making and the total emancipated decision-making scores?

The secondary purpose was addressed through the following research questions:

3. What is the relationship between emancipated decision-making and satisfaction with the decision about infant feeding method in women?
4. Does the combination of the subscales of emancipated decision-making (empowerment, flexible environment, personal knowledge, reflection and social norms) predict satisfaction with the decision about infant feeding method in women better than any one element alone?

Hypotheses

Since the primary purpose of this study was exploratory, no a priori hypotheses are presented to address Research Questions 1 and 2. This research study tested the following hypotheses concerning Research Questions 3 and 4:

1. Emancipated decision-making is directly related to satisfaction with the decision about infant feeding method in postpartum women.
2. The linear combination of the subscales of an emancipated decision-making process (empowerment, flexible environment, personal knowledge, reflection and social norms) predict satisfaction with decision-making better than any one element alone.

Theoretical Foundations

Definition of Emancipated Decision-making

Emancipated decision-making is a theoretical concept that describes a process of reaching a more positive state of being, a state of freedom in choice, by first acknowledging the affective experience of oppression. The oppression is recognizable when it produces a dilemma in decision-making by socially sanctioning one alternative as superior to the others, thereby imposing personal and social implications. To arrive at an emancipated decision, the woman must cognitively reflect upon the choices. Reflection can be accomplished with or without dialogue. An emancipated decision is arrived at using personal knowledge in combination with empowerment. An emancipated decision requires a flexible environment and produces satisfaction with the decision (Wittmann-Price, 2004).

The concept of emancipated decision-making has been derived from this author's synthesis of specific concepts from Critical Social, Feminist and Freire's Emancipatory Education Theories (Freire, 1970; Marx & Engels, 1976; Perry, 1994). Critical Social Theory clearly defines social norms, reflection, and personal knowledge. Freire's Theory of Emancipatory Education elaborates on the importance of reflection and Feminist Theory explains the need for empowerment through knowledge and the importance of a flexible environment. Each of these five subconcepts, empowerment, flexible environment, personal knowledge, reflection and social norms, are further developed in the theory of emancipated decision-making (Wittmann-Price, 2004). Each contributing theory will be discussed briefly prior to the presentation of the Wittmann-Price Theory of EDM.

Contributing Theories

Critical Social Theory

Critical Social Theory started in Germany in the 1920's as the Frankfurt Theory. The Frankfurt theorists were a well-known group of philosophers who developed Critical Social Theory from the foundational works of Marx (Marx & Engels, 1976) and Hegel (1960). Originally Critical Social Theory explained the divisions of labor and unequal profits in society. Critical social theory was further developed as a theory of knowledge out of its materialistically based foundations. Critical Social Theory incorporates the conflict theory of society which deals with domination of individuals as a major premise. Critical Social Theory has been explained and applied in many ways, with many references to labor and economic issues but the main concept of Critical Social Theory is

that society applies unequal power which causes oppression and this can therefore be applicable to many human situations creating the need for emancipation (Hegel, 1960; Marx & Engels, 1976; Paley, 1998).

Critical Social Theory identifies oppression by using immanent critique. Immanent critique is a method of examining a social system to uncover discrepancies between values and reality. The term, hegemony, in Critical Social Theory, refers to a dominant class forcing their ideals and values on a non-dominant group for control. In order for control to be effective, the dominant class influences the consciousness of the non-dominant class so that they accept the ideals of the dominant class as the best way, which then becomes the social norm (Harden, 1996). This researcher defined social norms as influences that affect decision-making. Social norms are a subconcept of emancipated decision-making (Wittmann-Price, 2004).

Jürgen Habermas, a second-generation Frankfurt theorist, is credited with the most current philosophical interpretation of Critical Social Theory. In the 1960's, Habermas developed praxis for implementing equality to counteract the oppression described in Critical Social Theory. He used a modality called, "communicative action" (Habermas, 1969). This methodology is said to reduce social injustice or oppression through true and meaningful human dialogue (Duchscher, 2000).

Habermas' work highlights three important concepts of Critical Social Theory which he developed in two historical phases. The first phase identified three classifications of knowledge and included empirical analysis, hermeneutic interpretation, and critique of domination (Duchscher, 2000). He concluded that all three ways of

knowing are needed and complement one another. Empirical analysis emphasizes the quantitative research component of issues, hermeneutic interpretations take into account the personal implications of an issue and critique of domination recognizes the social norm of the issue. These three important concepts outline a complete knowledge development that recognizes scientific knowledge, personal knowledge and social influences as inseparable in humans (Duchscher). Emancipated decision-making, as identified by this researcher, takes into account various modalities of knowledge, personal, professional, and social reflecting the three knowledge components outlined by Habermas (Wittmann-Price, 2004).

The second phase of Habermas' philosophical development dealt with further defining and developing hermeneutic interpretation in the form of communicative action. This phase concentrates on the power of communication as one of the most important forms of learning. Communicative action often takes the form of dialogue. It can also be operationalized as reflection which can take the form of communicative action between two individuals or also interpreted as an internal awareness process (self-dialoguing) (Mill, Allen & Morrow, 2001). Communicative action is considered by Habermas as valid knowledge, ontologically sound because of the importance of language and human interaction in relation to the universe and the development of knowledge. Through dialogue, relationships between phenomena and individuals can be explored (Habermas, 1969).

A methodology frequently used to operationalize the philosophy of Critical Social Theory is derived from Heidegger (1949). Heidegger believed that person and reality are

perceived and it is the interpretation of the lived experience that constitutes true knowledge. This implies that personal knowledge is a true and important knowledge because it comes from the experience of the individual. A person's experiences can not be separated from the person and a person's interpretation of the experience is part of their personal knowledge (Polanyi, 1958). Personal knowledge is assumed to be needed by a person to know which choices are right for them when confronted with a decision. Therefore, personal knowledge has been identified by this researcher as an element of emancipated decision-making (Wittmann-Price, 2004).

Nursing, as scientific inquiry, supports Critical Social Theory as a framework in knowledge development because of its capabilities of including various types of knowledge development. It is also capable of exposing inequities in health due to knowledge of social factors that influence the healthcare system. Using Critical Social Theory as a framework for nursing science has been argued in the literature. Some nursing leaders suggest that Critical Social Theory is an inadequate framework by itself because it does not fully embrace and expand on empirical knowledge in the same respect as hermeneutic and social knowledge (Gortner, 1993). Other nursing leaders support Critical Social Theory as a sufficient framework because it is congruent with nursing theories and philosophies and is comprehensive enough to incorporate all of nursing knowledge (Holter, 1995).

Wells (1995) used Critical Social theory in a study on decision-making and discharge teaching. This study demonstrated the relationship of individuals with the social, political and economic environments that influenced discharge decisions. The

study concluded that decision-making was influenced by systemic forces more than patient's individual needs. Wells used Habermas' argument that "social structure...is inseparable from social action...and that structure can constrain action" (Wells, p. 48).

Feminist Theory

There are many forms of Feminist Theory, but the major concept across all feminist theories is that there is societal power or domination over women, causing oppression and denying equality (Arslanian-Engoren, 2002). Epistemological views about women's position or place in the world differ in the various feminist theoretical approaches; many of them conclude oppression affects knowledge, education and economy (Perry, 1994).

Historically, feminist theory conception was marked by the Seneca Falls Convention in 1848, spearheaded by Elizabeth Cady Stranton who drew up a Declaration of Sentiments outlining 18 unequal practices against women and 11 resolutions that would enhance women's political and economic status. This document included the proposal for women to vote (The Seneca Convention). Liberal feminism was a direct outgrowth of the Seneca Falls Convention. Liberal feminists view issues similar to liberal political issues and stress equal opportunity for women in areas of individualism, privacy, equality, autonomy and self-fulfillment (MacPherson, 1983). Liberal feminism bases comparison on men which limits its usability in post-positivist philosophies and collective societal enhancement. Equality was basically a personal issue to be fought for on the home front (Pohl & Boyd, 1993).

Radical feminism was a second phase which emerged from the 1960's women's

liberation movement. Radical feminists hold the belief that oppression is fundamental and permeates all social structure and places the blame of this on biological differences (Jagger, 1988). Radical feminists take into account women's ways of knowing as unique and different (not just separate) from men (Pohl & Boyd, 1993).

Socialist Feminist Theory is the newest version of the theory and also evolved from the women's liberation movement of the 1960's. It is a mix of Feminist Theory and Critical Social Theory and believes that reality includes biology and society and is driven by labor as the praxis. It reveals inequalities in a public sense and rejects the individualism of liberal feminist theory. This view proposes that there is inequality of assigned work roles between women and men and calls for planned social change. Socialist Feminist Theorists believe that valid knowledge can be empirically, personally or socially derived (Jagger, 1988).

Feminist Theory has had a great influence on nursing and has increased awareness of issues that cause discrepancies in women's healthcare. This is evident in the current research that differentiates cardiovascular disease research and treatment among women (Arslanian-Engoren, 2002).

Feminist Theory also validates personal knowledge as true knowledge and has highlighted the fact that the majority of science has been built on a patriarchal tradition which has established empirical knowledge as superior to other knowledge. Feminist Theory recognizes that empirical knowledge, or that knowledge base gained through systematic investigation, observation and testing, is only one valid type of knowledge (Berragan, 1998). Feminist Theory also explains that the unequal distribution of

empirical knowledge over other knowledge is because early in history, women assumed the role of caregiver, allowing men more time for scientific study which empowered men with professional knowledge (Perry, 1994). This study recognized that empirical knowledge is one important way of knowing and the knowledge gained from systematic investigation empowers the knower with information needed when faced with healthcare choices (Wittmann-Price, 2004).

Feminist theory directly supports other subconcepts of emancipated decision-making. There are two dominant paradigms, normative and descriptive, which exist in decision-making. The normative paradigm comes from Aristotelian logic and focuses on how decisions ought to be made. Feminist theory falls under the descriptive paradigm focusing on how decisions are actually made. It supports innovative ways of obtaining knowledge and expanded meaning. Within this paradigm is the fundamental premise of equal rights as inherent in human nature (Arslanian-Engoren, 2002). Nursing feminist theorists proposed equal rights, equal treatment and caring as basic values (Bevis & Watson, 1989). Only under the premise of equality can the growth of voice or empowerment by knowledge acquisition exist and oppression or silence is eradicated. Feminist theory understands that voice requires safe space (Johns, 1999). Therefore, safe space is interpreted, by this researcher, as a flexible environment in which to enact choice and it is therefore a necessary subconcept in emancipated decision-making (Wittmann-Price, 2004).

Freire's Emancipatory Educational Theory

Paulo Freire (1970) proposed that educational institutions are powerful enough to

promote an emancipated society. He expanded on the description of social norms that oppress from an educational standpoint. Freire believed that oppression serves the purpose of dehumanization by producing a “culture of silence” that is exploited for political or economic gain. Because of this intellectual, emotional and psychological enslavement, the oppressed develop a “fear of freedom” (Freire, 1970, p. 36) in exchange for perceived security.

The outcome of emancipated education for any group is to equalize power between information giver and receiver in order to enable free choice and create an environment of true humanism that may extend into all social systems (Freire, 1970; 1992; 1998). It was not until Freire’s (1970) Pedagogy of the oppressed that educators seriously considered the social aspect as a determinate of the educational stance of people. The methodologies proposed by Freire as necessary infusions into the classroom to create an equalitarian society of learning support both critical Social Theory and Feminist theory philosophies. They include methodologies such as establishing teachers and students as co-learners with emphasis on inquiry rather than on the knowledge acquisition. Freire proposes the establishment of a collaborative climate in which students take responsibility for their learning.

One of the main components of Freire’s Emancipatory Education model is reflection, characterized by critically thinking about alternatives. Reflection can take the form of interpersonal dialogue or self-dialogue, both producing an internal awareness. Freire believed that traditional educational methods alone foster oppression because they do not encourage the reflection needed for critical thinking (Romyn, 2000). It is

important to reflect on issues in order to recognize their inherent personal and social aspects. Reflection is also needed to critically think about the information gained from personal and empirical knowledge in order to synthesize it into a decision (Fahrenfort, 1987).

Therefore, reflection has been identified, by this researcher, as an element of emancipated decision-making (Wittmann-Price, 2004). Reflection as an awareness has also been described in direct relation to the decision-making process in considering how knowledge is applied to choices that reflect values and preferences (Mitchell, Tetoe & O'Connor, 2001).

Summary of Theories

Critical Social Theory recognizes the relationship of society and individuals as inseparable. Critical Social Theory and Freire's Emancipatory Education Theory recognize that oppression exists within social norms. Feminist theory recognizes societal oppression as inherent and specifically applied to women. Critical Social Theory and Freire's Emancipatory Education Theory suggest that important subconcepts of emancipation are reflection and personal knowledge. Feminist Theory further defines the need for empowerment through professional knowledge and the need for a flexible environment in order for women to reach an emancipated decision.

The Wittmann-Price Theory of Emancipated Decision-making (EDM)

No other theory currently exists that models the decision-making process as described in the Wittmann-Price Theory of EDM. A synthesis of the subconcepts of empowerment, flexible environment, personal knowledge, reflection and social norms

from Critical Social Theory, Feminist Theory and Freire's Theory of Emancipatory Education was used to develop the Wittmann-Price Theory of EDM. Each of the foundational theories contributes specific subconcepts for the explanation of the phenomena of emancipated decision-making. The following section provides a description of the theory within the world views and the definitions of the nursing metaparadigm concepts of person, environment, health and nursing (Fawcett, 2005).

World View

Philosophies in nursing, which derive theory, have been categorized into one of three world views that reflect specific ontological and epistemic insights. The reaction world view supports empirical development of knowledge. Objective phenomenon, systematically studied produces true knowledge. Within this world view there is predictable change in humans as reactionary beings to the external environment. Humans are bio-psycho-social-spiritual beings that are a sum of their parts. This view does not take into consideration the holistic philosophy of the interaction world view. The interactive world view philosophy conceptualizes humans as a whole being that cannot be reduced to specific parts. The interaction world view holds that humans and the environment are in constant interaction in a reciprocally beneficial process which produces change on continuum. Reality, in the interaction world view, is based on both subjective and objective data and is context driven. The third world view is simultaneous action. Simultaneous action views humans as identifiable by patterns of self organization that are in a continuous change process. Knowledge within this view is personal and recognizes feeling, values, thought and choices (Fawcett, 2005).

The Wittmann-Price Theory of EDM supports an interactive world view and assumes the environment is an inseparable part of human development. Oppression is ever-present in the environment. Oppression is contextual and on a continuum and directly influences women in their process of decision-making. Emancipated decision-making recognizes and reduces oppression thereby fostering relative freedom of choice. Freedom to choose the best option for oneself is a fundamental human need and right. Emancipated decision-making produces a more positive state of being. Women who make emancipated decisions are more satisfied with the decision. The following sections define the metaparadigm concepts of nursing within the practice theory of emancipated decision-making.

Person

A person is a holistic being who receives nursing care as a necessary component of the complex environment for the purpose of attaining or regaining emancipated healthcare decisions. A person is in constant interaction with the environment. A person is both a holistic and a social being and is affected by the environment. This definition was synthesized from the foundation work of Erickson, Tomlin, and Swain (1983) and Leininger (1979).

Environment

Environment is a complex concept viewed as both internal and external factors that affect the person. The environment includes not only physical space but also feelings and attitudes that surround and extend into the person. Environment is not “time grounded”, but includes social and personal issues of the past that have influenced the

present as well as those issues that are forming and will influence the future in which the present is infinitely evolving. The environment includes a person's interpretation of all past, present and future events. The environment includes culture and social factors that influence decision-making. This definition was synthesized from the foundation work of Erickson, Tomlin, and Swain (1983) and Leininger (1979). The environment also includes how each person interprets the totality of self and environment to uniquely find meaning in situations in an individualistic manner and transform that meaning into personal knowledge. This aspect of the definition of environment was synthesized from Berragan (1998).

Health

Health is culturally and socially defined, valued and practiced and is the ability of the individuals or groups to be satisfied through emancipating decisions. It is a process of maintaining individuality in self while recognizing the self as part of environment. Health includes the ability to make choices that are emancipating and satisfying. This definition was synthesized from the foundation work of Erickson, Tomlin, and Swain (1983) and Leininger (1979).

Nursing

Nursing is the science and art of purposeful interaction with a person to promote and support emancipated decision-making. Nursing supports emancipating healthcare decisions to promote self in a positive way which includes the physiological, psychological, spiritual and emotional self. The role of the nurse is facilitation, which provides the person with a flexible, empowering, reflective environment that recognizes

social norms and personal knowledge and encourages free choice to enhance their satisfaction. This definition was synthesized from the foundation work of Erickson, Tomlin, and Swain (1983) and Leininger (1979).

Summary of the Wittmann-Price Theory of Emancipated Decision-making (EDM)

In the Wittmann-Price Theory of EDM the person and environment are in constant interaction. The person attempts to maintain emancipation by equalizing power against persons, groups or systems that attempt to impose oppression. Environments, which includes both external and internal, are intertwined with sources of power, both obvious and obscure, that can be used for positive or emancipating outcomes or negative or oppressive outcomes depending on the intent. A person can never be completely separated from the environment and its social and cultural context and the environment cannot be separated from the person. In this practice theory, environment is conceptualized as being on a continuum from flexible to non flexible. A flexible environment is one in which the person can experience reflection and awareness of personal knowledge. A flexible environment is one that can be emancipating because it respects and honors different types of knowledge including personal knowledge and knowledge gained from reflective practices (August-Brady, 2000). Conversely, non flexible environments include individuals and groups that do not entertain alternative knowledge sources (Allen, 1985).

The Wittmann-Price Theory of EDM has been derived from the concept analysis of emancipated decision-making and has assumed that specific conditions exist in reality. The Wittmann-Price Theory of EDM includes the following assumptions:

1. There is an oppressive force originating internally or externally and it is recognized by women as an impingement upon free choice.
2. Social norms are a possible negative influence and can be oppressive.
3. Oppression indicates that there is a power applied to a situation unequally because of gender, race, socio-economic status, culture, healthcare status, or differing biological functions of women.
4. Oppression in healthcare hinders women's freedom of choice about healthcare issues that directly affect them.
5. Women must recognize oppression as a state of disequilibria between what they want, or perceive as best for themselves, and what society perceives as best for them.

A summary of critical subconcepts needed to arrive at an emancipated decision are:

1. Women are cognizant of oppressive powers that are social norms that affect their decision-making process.
2. Women are empowered with the knowledge needed to understand or comprehend all the viable alternatives or choices of a decision.
3. Women use personal knowledge in conjunction with empowerment to make an emancipated decision.
4. Women have the opportunity to use reflection to synthesize personal and professional knowledge to evaluate the alternatives.
5. The environment is flexible enough to support women's decisions without

imposing further oppressions.

6. Women understand the social responsibility of their decisions as they relate to family, community and larger society and have no residual guilt or internalized repercussions for their decisions.

This researcher posited that the Wittmann-Price Theory of EDM promotes positive patient outcomes by supporting an emancipated decision-making process as a modality to increase woman satisfaction with decisions. An emancipated decision is one mechanism to foster individualism and freedom, two innate and important human aspects within the realm of healthcare. Outcomes of an emancipation decision-making process include:

1. The decision reflects an issue relevant to society in the healthcare of women.
2. The decision is a reasonable and viable solution to a choice.
3. Women make decisions without coercion.
4. Women arrive at a decision after reflection.
5. The decision is perceived by women as satisfying thereby promoting a more positive state of being.

Definition of Terms

The following terms are defined for the purposes of this study:

1. Emancipated decision-making is a theoretical concept that describes a process of reaching a more positive state of being, a state of freedom in choice, by first acknowledging the affective experience of oppression. The oppression is

recognizable when it produces a dilemma in decision-making by socially sanctioning one alternative superior to the others thereby imposing personal and social implications. To arrive at an emancipated decision, the woman must cognitively reflect upon the choices. Reflection can be accomplished with or without dialogue. An emancipated decision is arrived at using personal knowledge in combination with empowerment. An emancipated decision requires a flexible environment and produces satisfaction with the decision (Wittmann-Price, 2004). Emancipated decision-making was measured by total scores on the EDMS.

- a. Empowerment is the process that provides the resources, tools, and environment to develop, build, and increase ability and effectiveness of others to set and reach goals for individual and social needs (Hokanson-Hawks, 1992). For the purpose of this study, empowerment was the provision of information to women about healthcare alternatives by healthcare professionals and was measured by the scores on the empowerment subscale of the Wittmann-Price EDMS.
- b. Flexible environment is an internal and external environment that is responsive and resilient to increased choices which enhances self-esteem and satisfaction (August-Brady, 2000). For the purpose of this study, flexible environment was defined as an environment that allows unopposed enactment of any chosen alternative as perceived by the woman as measured by the scores on the flexible environment subscale of

on the Wittmann-Price EDMS.

- c. Personal knowledge is a way of knowing that has components of self-awareness. It is both subjective and objective and is described as the ability to understand one's self. Personal knowledge influences everything one does because it is being aware of one's own personal feelings (Berragan, 1998). For the purpose of this study, personal knowledge reflected a woman's awareness of how various healthcare alternatives affected her in her current situation and was measured by the scores on the personal knowledge subscale of the Wittmann-Price EDMS.
- d. Reflection is a technique that encourages critical thought either with oneself (self-dialogue) or another individual or group (dialogue) (Shor, 1992). It is a critical thinking process that assists the client to develop the learning technique of "knowing thyself". It is a self-analytical process that surfaces contradiction between what one intends to achieve in any given situation and the way one is behaving (Johns, 1999), and considers both the person and the situation (Penney & Warelow, 1999). For the purpose of this study, reflection was defined as a cognitive, interactive process a woman has engaged in when considering alternatives and was measured by the scores on the reflection subscale of the Wittmann-Price EDMS.
- e. Social norms refer to a woman's awareness that the external environment has sanctioned one of the possible alternatives as more acceptable than another. It originates as recognizing that knowledge development always

occurring in a social context and social context is capable of exerting unequal power and can exert influence over knowledge thereby influencing individual perception (Berragan, 1998). For the purpose of this study, social norm was defined as an awareness of society's sanctioning of the alternatives being considered and was measured by the scores on the social norm subscale of the Wittmann-Price EDMS.

2. Infant feeding methods included in this study are breastfeeding, bottle feeding or combination feeding (breastfeeding with bottle supplements) and were defined as:
 - a. Breastfeeding, for the purpose of this study, meant feeding the infant by exclusively putting the baby to the mother's breast and not giving the infant any other foods or drink in addition to breastfeeding. The exceptions were the feedings of medicines and vitamins or mineral drops (Labbok & Krasovec, 1990; World Health Organization, 2004).
 - b. Bottle feeding, for the purpose of this study, meant feeding a baby from a bottle, regardless of what is in the bottle, even expressed mother's milk (World Health Organization, 2004).
 - c. Combination feeding (breastfeeding with bottle supplement), for the purpose of this study, meant breastfeeding at least 50% of the time and supplementing with bottles 50% or less of the infant's feedings. This included giving the baby some breast feeds and some bottle feeds (World Health Organization, 2004).
3. Satisfaction with decision-making is a positive feeling about a decision that

successfully meets the client's expectations and incorporates the client's values on which the client is the ultimate authority (Mahon, 1996). This was measured by the total scores on the Satisfaction with Decision Scale (SWD) (Holmes-Rovner et al., 1996).

Significance of Study

Nursing Practice

This study added to the body of knowledge about decision-making in women's healthcare. It explored subconcepts of decision-making and included social norms specific to the female gender. Pierce and Hicks (2001) stated that nursing needs to develop decisional science in order to deal with the increase in healthcare alternatives presented to patients. In order to shift the current paradigm from a paternalistic environment to a collaborative woman-provider relationship, decisional science must be better understood.

This study may lead to further discussion and exploration of the role of the professional nurse in facilitating the decision-making processes of women in their care. Professional nursing may find it difficult to facilitate emancipated decisions without further exploration and reflective consideration of their role in an oppressive social system (Harden, 1996; Romyn, 2000).

Nursing Education

Shor (1992) classified schools as systems of socialization that reflect the values of society. Critical Social Theory has been proposed as the educational tool to look beyond the Tylerian (Tyler, 1969) educational philosophy of behaviorism and linear knowledge

acquisition. Freire (1970) first popularized the pedagogy of emancipated education and then further expanded and elaborated on the concept by implicating that educational methods can emancipate society (1992). Freire explained the emancipated educational methodologies for teaching in Teachers as cultural workers: Letters to those who dare to teach (1998) as enhancing critical reflection by equalizing the power within the classroom through promoting the student's self awareness by discussion.

Both Critical Social Theory and Feminist Theory based their philosophies on power. Feminists view power as oppressive to women by virtue of the way it was developed and executed within all social systems. More specifically, the educational system applies negative power to women, thereby oppressing them by “marginalizing them and silencing them” (Gore, 1993, p.120).

Emancipated decision-making, from both a Critical Social Theory and Feminist Theory paradigm, has great implications for nursing education since the majority of nursing students are female. However, developing EDM in nursing may not be without implementation difficulty since oppression is insidious and may be difficult to recognize by those being oppressed. Nursing leaders have proposed and termed emancipatory type learning as a more caring curriculum (Bevis & Watson, 1989). A more caring curriculum in nursing that promotes reflection will benefit both men and women nursing students. Sensitizing men to emancipatory education will assist the entire nursing profession to grow in decisional science and promote positive healthcare outcomes in women's health. Owen-Mills (1995) endorsed a wider vision of emancipation by stating, “The challenge for nurse educators, however, extends beyond the confines of an institution and into the

homes, hospitals and communities where nursing is practiced. For a caring curriculum to be truly emancipating, its effects must become internalized as a way of being” (p. 1193)

Nursing Science and Research

This study is important to nursing because it contributed a new practice theory to nursing science and a new instrument to nursing research. This study is also important because nursing practice in women’s healthcare reflects the historical and social construct of gender biases. Current scientific knowledge may neglect recognition of personal knowledge as a true knowledge source. Individual choices made on the assumption of “doing what is expected” rather than “doing what one wants” may produce dissatisfaction with the decision.

This study added insight to decisional science specifically applied to women. The new knowledge that this study generated may increase awareness of the possible effects of social norms on women’s healthcare decisions. It was proposed to enhance positive decision-making by considering various sources of knowledge and environmental influences.

This study also aimed to enhance nursing care in women’s health by promoting decisional satisfaction. From this initial research other possible applications are derived for expanded investigation and development of the Wittmann-Price Theory of EDM.

Chapter Summary

The primary purpose of this study was to test subconcepts of emancipated decision-making in women’s healthcare, using women’s choice of infant feeding method as the clinical exemplar. The second purpose was to explore the relationship of

emancipated decision-making and satisfaction with the decision. Emancipated decision-making in women's healthcare is a theoretical concept grounded in history, explained by Critical Social, Feminist and Freire's Emancipatory Education theories and described through extensive clinical practice. This exploration served to test and refine subconcepts in the continuing theoretical development of the Wittmann-Price Theory of EDM.

The subconcepts of EDM that have been discussed and defined include empowerment, flexible environment, personal knowledge, reflection and social norms. These subconcepts have been explored within an emancipated decision-making process. This investigation explored the degree to which an emancipated decision predicts satisfaction with the decision. It must be noted that this study did not evaluate the woman's satisfaction with the choice of infant feeding method. This study increased knowledge about decision-making in the nursing care of women and contributed to the development of the Wittmann-Price Theory of EDM.

CHAPTER 2

REVIEW OF LITERATURE

Introduction

The primary purpose of this study was to test subconcepts of emancipated decision-making in women's healthcare, using women's choice of infant feeding method as the clinical exemplar. The secondary purpose was to explore the relationship of an emancipated decision-making process and satisfaction with the decision. Emancipated decision-making in women's healthcare is a theoretical concept grounded in history, explained by Critical Social, Feminist, and Freire's Emancipatory Education theories and described through an extensive review of the literature and this researcher's clinical practice. This exploration served to test and refine subconcepts in the ongoing theoretical development of the Wittmann-Price Theory of Emancipated Decision-making (EDM).

This chapter presents a review of the literature in five areas that support the concepts of an emancipated decision-making process. The first area of literature reviewed consists of a brief synopsis of the concept of oppression. Oppression of women is the underlying assumption for this research and a discussion of its existence lays the foundation for the concepts being explored.

The second area of literature review highlights historical accounts that represent periods of emancipation which directly affected women's rights and, therefore, choices. These accounts demonstrate emancipation, in recent American history, on a social level, thereby substantiating oppression as an existent phenomenon.

The third area of literature review concentrates on the use of the concept of emancipation in clinical nursing practice. This review conveys the inconsistent use of the term. The most prevalent application of the concept in nursing takes the realm of patient education. A small amount of literature uses emancipation as a concept describing patient care situations.

Fifty articles were listed for the key words emancipation and woman care in the Cumulative Index of Nursing and Health Literature (CINAHL) and Medline (1983-2005) electronic databases. No applicable articles were retrieved from psychINFO, PubMed, and Applied Science and Technology Info databases. Of the 50 articles, six were reviewed and critiqued due to their applicability to direct clinical practice. Other articles were not retrieved because they were studies about specific cultural populations or reviews of concept analyses of related terms to emancipation. Articles were not retrieved for review that were specific to interpersonal relationship development, emancipation as a term used in clinical nursing practice was maintained as the focus.

The fourth area of literature being reviewed is theory development. It includes four sections which reflect decision-making theories, decisional science development, decision-making applied to clinical practice in women's healthcare and decision-making applied to non gender healthcare. Studies about decision-making and decision-making about healthcare issues were searched with keywords decision-making theories and women's health yielding 230 articles from 1983 to 2005 using the databases of medLINE, CINAHL and psychINFO. Twenty-seven articles were reviewed that contained information about decision-making theories or specific decision-making

clinical situations in women's health.

Articles that discussed decisional science or involved decision-making about specific healthcare conditions were included in the following review even when they did not study gender specific issues. The healthcare issues for women covered in this review span a wide range of women's issues including; general decision-making (14), breast cancer treatment alternatives (4), hormone replacement therapy (HRT) (5), hysterectomy (1), acute myocardial infarction (AMI) (1), HIV and pregnancy (1) and prenatal testing (1). Five articles were retrieved about decision-making on health issues facing both genders for evaluation of consistency in theory and context. These included studies using decisional aids for participants dealing with schizophrenia, cognitive impairment, stroke, lung cancer and mechanical ventilation.

The last area of literature reviewed pertains to choice of infant feeding method. Represented is a review of research studies focused on identifying the reasons which influence women's choice of an infant feeding method. This search also yielded research applying behavioral theories in relation to decision-making. This search was done through the databases of CINAHL and medLINE from 1983 to 2005. The results yielded 162 articles containing the keywords of infant feeding and decision-making. Sixty articles were deleted from the review because they focused on health complications as intervening variables such as HIV, neonatal intensive care infants, or female partner abuse which are issues above and beyond the scope of this research. Of the 102 articles remaining in the search, 72 were retrieved and reviewed for existing research on variables associated with choice of infant feeding method. Bottle feeding advantages yielded 26

articles though CINAHL but only two articles actually promoted bottle feeding as a reasonable and positive infant feeding method. Bottle feeding was then searched through ancestry means yielding three articles that supported bottle feeding in anecdotal form. This literature review about infant feeding method is divided into two sections, breastfeeding and bottle feeding.

The literature search was approached from five distinct topics to synthesize literature supporting the conceptual framework of emancipated decision-making within the specific clinical exemplar of infant feeding method. Emancipation linked directly with decision-making in women's health is an unexplored theoretical construct rendering it impossible to extract from the literature in pure form, therefore the literature searches focused on supporting topics.

Brief Literature Review Focusing on Oppression

Oppression is defined as an unjust or excessive exercise of power that is dishonest, unfair, wrongful, or burdensome and produces an inequality of bargaining power resulting in one party's lack of ability to negotiate or exercise meaningful choice (Merriam-Webster Online Dictionary, 2005). Oppression is a constant state and a timeless conflict that exists in society pitting tradition against social change (Penney & Livingston, 2004). The goal of scholarship is to transcend any perspectives that place any one human being or group superior to others (Nicholson, 1990). Oppression has been long applied specifically to women. Women have been systematically disadvantaged in many social micro systems by oppression. Historically, women's roles have been synonymous with the role of wife and mother, putting them at a disadvantage

educationally and occupationally (Roberts, 1981). Family roles, stereotyping, and educational oppression plague women's true voice or ways of knowing. Knowledge and truth in academia which sets the stage for social and political knowledge has been shaped by the male-dominated culture (Belenky, Clinchy, Goldberger & Tarykem, 1986; Perry, 1994). Emancipation can only exist through the awareness and understanding of oppression. Women have a unique experience because oppression is many times gender specific. Recognizing oppression is stated by Evans (1997) as important because, "Only then can we begin to image what it will really mean for women to be citizens, full participants in the decision-making process that shapes our future" (p. 6).

Highlights of Historical Accounts Representing Emancipation

Specific events demonstrating oppression of women which resulted in an emancipating process producing decisional freedom will be reviewed briefly from the past and recent American history as an anthology. This anthology illustrates the invasive, cyclical and recurring nature of oppression that affects women's rights and therefore decision-making in the United States.

The following brief historical critique of events illustrates oppression as a pervasive factor, obstructing women's rights and therefore decision-making about healthcare and supports the need for recognition of emancipated decision-making in women's healthcare. Oppression itself is often a difficult phenomenon to recognize but is overtly demonstrated by an unfair practice imposed on a person or group that has some type of similar attribute (Johns, 1999). Oppression at times leads to emancipation when it is recognized. This transcendence from oppression to emancipation usually concentrates

on a specific oppressive condition or set of conditions that is depicted among a pervasive oppressive system. A focal issue that is oppressing is identified and publicly exposed gaining recognition as an unfair practice but the underlying oppressive social system remains intact. The recognition of a focal issue can lead successfully to an emancipating process if the environment is conducive to change or flexible enough to embrace a new paradigm and support change. This may be difficult because the same social, economic, and political environment that applies oppression must, after conscious awareness, provide the supporting structure to sustain the emancipation process. A limited number of oppressive conditions that resulted in emancipation for women and women's health will be highlighted, demonstrating the insidious nature of oppression and emancipation as it relates to women in society and healthcare (Novarra, 1980; Roberts, 1981; Schneir, 1972; Weisman, 1998).

1920's Era of Women's Health

The 1920's brought forth a clear attempt to denounce oppression and promote emancipation for women. After many years of campaigning for the right to vote, the struggle was recognized and publicized, beginning with a few feminist leaders, until it collected strength as the Suffrage Movement. On August 26, 1920, the Equal Rights Amendment was signed into the Constitution of the United States as the 19th Amendment. It was the culmination of years of oppressive struggle by women. The amendment simply states that voting privileges cannot be denied because of sex (Evans, 1997).

The Progressive Era of women's health movement coincided with the Suffrage

Movement. This era of reform enhanced women's choices on two important issues, birth control and better prenatal care (Weisman, 1998). Margaret Sanger fought to promote women's health by legalizing birth control, thereby providing choice in reproductive issues. This emancipation process resulted in the first American birth control clinic being established in 1916 in Brooklyn, New York and the passing of the Shepard Towner Act of 1921 to improve women's health by increasing maternal services (Schneir, 1972).

1960's Era of Women's Health

Another inequality of women's rights resurfaced again in the 1960's as more and more women joined the workforce to assist with the economic security of the family. This time women called for a Women's Liberation Movement. This emancipation process focused on the economic oppression of women, a more general and insidious inequity that resulted in amendments ensuring Equal Opportunity Employment (EOE) (Novarra, 1980).

The coinciding women's health movement of the 1960's to 1970's was a grass-roots movement constructed to challenge medical authority about women's healthcare issues. Historically the 1970's was a time when only 7% of physicians in the country were women, which represented no statistical increase since the post Civil War era when 6% of the physicians were women. The women's health movement addressed numerous issues, all promoting more informed choices. The concerns included general topics such as product safety, self-help information and accessibility, as well as specific issues relating to abortion, child birth practices, and excessive female surgeries such as hysterectomies, mastectomies, and cesarean sections. Some of the outcomes of this

movement included informative package inserts for birth control products and new Food and Drug Administration (FDA) policies using women in research studies. Advocacy groups that specifically addressed women's healthcare issues were started and remain intact such as the National Women's Health Network (Weisman, 1998).

1990's Era of Women's Health

The 1990s brought women's rights issues to a more professional level with an increased involvement of women in government and leadership positions. Women also increased their numbers in academia. During this time, the National Institutes of Health recognized the significance of women's healthcare issues and women's health offices were formed in federal and local governments. Research studies about women steadily increased in response to the Campaign for Women's Health lead by Anne Kasper editor for *New Directions for Women* and on the editorial board of *Women and Health* (Ruzek, 2002).

Historical Summary

This evolutionary review demonstrates that there has been some attempt to create the hegemony for correctional reform that ensures freedom in rights and choice for women in the larger society and healthcare system. In humanistic nursing paradigms, caring for women must be enacted by understanding the multifaceted issues surrounding women's health including the possibility that women's freedom to choose may in some way be oppressed. Aoki (2002) states this simply by remarking, "Receiving equal treatment is a human right" (p. 18). In addition, Aoki questioned intuitively the social position of current nursing practice by posing the question, "Are the rights of patients and

nurses usually compromised in some way?” (p. 17). Nursing must explore women’s decision-making about healthcare issues as a possible compromised area of care.

Use of the Concept of Emancipation in Clinical Practice

Studies about women’s healthcare education have produced preliminary supporting data for the concept of emancipation for the discipline of nursing. These studies have explored different patient education and delivery care methods in relation to nursing and the predominant medical model. Under the medical model, nurses have accepted the role of information “givers” about the prescribed treatment (Fleming, 1992). Emancipation, as part of patient education and care, is consistent with Western epistemology, which recognizes knowledge as power, and views the patient as an active participant (Arslanian-Engoren, 2002; Fleming, 1992). The concepts of empowerment and emancipation are often interchanged but it cannot be assumed that empowerment alone leads to emancipation (Johns, 1999; Ryles, 1999; Wittmann-Price, 2004). Patient education and emancipatory delivery of care is empowering but may not necessarily lead to emancipated decisions. The nursing practice literature applying empowerment or emancipation to patient care is lacking in research. The following are the scant studies referring to the concept of emancipation in direct patient care or patient education which empowers the patient in decision-making.

Jairath and Kowal (1999) studied patients’ post surgical pain management ($N=186$) by comparing influences on patients’ decision-making with their pain management expectations. This descriptive, non-random sample, which used a survey method, showed that significant variables ($p > .05$) for decisions about pain management were family and

friends. Social influences were a stronger indicator than professional knowledge in the empowered decision-making process. This was a good preliminary study, with an adequate number of subjects, identifying social norms as a variable in decision-making.

Burks (1999) promoted a model, anecdotally, where nurses practice conscientiously in the emotional/spiritual domain of patients to produce an environment that enhances empowerment. The milieu included the components of reflection and support for the purpose of producing confidence in the client. The environment proved to enhance positive attitudes and values when dealing with a chronic illness model. One of the main aspects of the model was enhancing the clients self care ability by having nursing relinquish control thereby allowing the client to act on her/his own behalf which encourages independent decision-making.

Henshaw (2001) investigated qualitatively the learning needs of women ($N = 36$) undergoing hysterectomies. The study was designed from a feminist philosophy and concluded that women are not a homogenous group of learners. Interviews revealed that, although all subjects felt that physicians held power by virtue of their knowledge, middle-class women felt they had more control of their healthcare decisions than working-class women. All women need empowerment through education but different learning needs may be attributed to women who take a more passive role. In this study empowerment was directly equated with education which demonstrates the need for empowering women through education for sound decision-making.

Leino-Kilpe and Luoto (2001) researched nurses ($N = 35$) taking care of patients ($N = 64$) afflicted with multiple sclerosis in order to develop emancipatory education and

promote self-care. This quantitative investigation took place in Finland where nurses working with multiple sclerosis patients found that social influences were not considered when evaluating the patient's knowledge and most professional education was directed toward the disease process and medical interventions. Quantitative data revealed that patient education focused on the etiology of the disease 40% of the discussion time ($N = 14$). An increase in empowerment, or patients participating in their own care, was realized when, based on unstructured interviews, individual knowledge was taken into consideration along with the evidence-based knowledge. Nurses took the time to find out what the patient knew about the disease process and how they interpreted the effects of the disease on their life. When social and personal factors were included in patient education the patients participated more in self-care and decision-making.

O'Brien, Woods and Palmer (2001) discussed, from a phenomenological viewpoint, a program to emancipate psychiatric patients by using the treatment modality of therapeutic community living. The purpose of the study was, "freeing up patients by enabling them to exist as human beings rather than patients" (p. 3). The heuristic purpose of a therapeutic environment was achieved through independent living and empowering the patient to become a contributing member of society. This article was a description of an emancipating patient program rather than a research based inquiry but captured two necessary subconcepts of emancipation; flexible environment and recognition of social norms. The program was stated to be emancipating by the authors because of increasing the flexibility in their environment.

Summary of the Use of Emancipation in Clinical Practice

The concept of emancipation has been used sporadically to describe different methodologies of nursing care in clinical practice. These emancipating methods range from pain management modalities to patient education (Henshaw, 2001; Jairath & Kowal, 1999). The common trend derived from the few studies available is the use of the concept of emancipation as a method that places more control of healthcare issues within the realm of the patient. This was done in varying ways such as environmental changes, recognizing social influences and through education.

Theory Development

Decision-Making Theories

The current healthcare environment has led experts to call for a reexamination of compliance or adherence by patients and replace it with a more active decision-making process. Decision-making has evolved from a provider directed activity to a collaborative activity called shared decision-making. Shared decision-making is a term recently coined for changes in patient-provider models to enhance patient rights (Rothert & O'Connor, 2001). Shared decision-making is progressing to a patient-centered modality which is congruent with the current healthcare milieu of the twenty-first century (Pierce & Hicks, 2001).

Pierce and Hicks (2001) wrote that all decisions are based on “decisional problems”, sometimes called decisional dilemmas, which include not only the alternatives of a decision but the possible outcomes and the probability attached to those

outcomes. They further explained that all decisions have at least four basic options, which are the alternatives to choose from. Three options include values, which are 1.) the personal appraisal of each outcome; 2.) uncertainties or probabilities of the outcomes of each choice, which can be derived from objective or subjective data; and 3.) the consequence or outcome which may present one option as more attractive than another. The fourth option “decisional hazard” in clinical practice, that is presenting one alternative as more attractive than another, thereby deterring adequate appraisal of other alternatives. Pierce and Hicks (2001) delineated clear goals and objectives of patient decision-making research in clinical practice. These include (a) helping patients become more efficient, given their limited physical and cognitive resources; (b) reducing the psychological stress of making the decision; (c) help patients avoid decision hazards; and (d) helping patients to arrive at decisions that accurately reflect their preferences and values. This theory supports emancipated decision-making by recognizing the importance of personal knowledge.

Janis and Mann’s Conflict Model of Decision-Making (1977) outlined five types of decision-making outcomes that can be identified when a person perceives a stressor in a life situation. The responses ranged from “unconflicted adherence” in which a person chooses to ignore making the decision, to a person who makes the decision vigilantly after conscientiously reflecting on all the alternatives. One of the antecedents in the conflict-theory model includes information gathering and recognizes the importance of communication with different sources for information. Another antecedent and mediating process of decision-making is evaluation of the risks of an alternative. The authors

recognized that many variables can be part of the decision-making process including personal attributes. According to this theory, only one method of decision-making, vigilance, leads to thorough planning for implementation and evaluation. The other four possible modes of decision-making, unconflicted adherence, unconflicted change, defensive avoidance and hyper vigilance, lead to incomplete decision-making. Vigilance best describes a reflective process.

Smith (1999) divided nurses' decision-making about patient care alternatives into two major components, rational and phenomenological or intuitive, in the family-centered care realm of neonatal intensive care units. The rational decision-making process is based on evidence-based research while the phenomenological process is based on Benner's (1984) intuitive knowledge derived from practice. Smith concluded that both types of decision-making knowledge are valid and went on to describe seven steps to arriving at a decision. The steps included defining the problem, data collection, identifying goals, establishing options, deciding on an option, implementation, and evaluation. This process mimicked the nursing process as a dynamic process and the author encouraged the family to take part in decision-making to enhance neonatal care. This theory supports the need for several types of knowledge.

Decisional conflict, according to O'Connor, Jacobson and Stacey (2002), is an important component of change and occurs when there is uncertainty about which course to choose. Decisional dilemma occurs when none of the alternatives are attractive. Signs of decisional conflict include verbalization about the uncertainty, expressing concerns about the option, unable to choose clearly between two alternatives, delaying the

decision, questioning personal values, being preoccupied with making the decision and experiencing emotional stress over the process. Two common sources of decisional conflict come from the inherent disadvantages of the choices and the modifiable factors that make a difficult choice more involved. The modifiable factors are lack of knowledge, unrealistic expectations, unclear values and perceptions of others, social pressures, lack of support, lack of self-confidence, and lack of resources.

The Ottawa Decision Support Framework is an instrument or decisional aid that can be used to guide clients in making decisions in clinical practice. The authors devised the tool in 1996 as a framework for assisting patients with decisions that produce conflict or decisions that are produced from a new situation such as a medical diagnosis (O'Connor, Jacobson & Stacey, 2002). The tool has been used in more than 12 studies ranging from hormone replacement therapy to prenatal testing. The criteria for a decision depended on the perception of the alternatives by the patient, how the perception of others will influence the patient, resources such as personal abilities and external support, and personal characteristics which include demographic and diagnostic information relevant to the decision.

Summary of Decision-Making Theories

Decision-making theories, although include different variables, have identifiable trends. Decision-making is a patient process that has clear antecedents including a stimulus, risk appraisal, choice awareness, gathering information, and an evaluation process (Noone, 2002). Many decision-making theories include consequences of the decision-making process which can follow either a path of acceptance or one of

reevaluation that again leads to another decision-making process. Most theories include some type of social influence and patient perception as affecters of the process (O'Connor, Jacobson & Stacey, 2002; Smith, 1999).

Decisional Science

Rothert and O'Connor (2001) elaborated on the construct of shared decision-making and outlined characteristics of the phenomenon as a process with specific components. The components of shared decision-making in healthcare are as follows: it has at least two people participating, one as the provider and one as the patient, both parties are involved in the decision-making, information is shared, and finally, both parties agree on a decision. An important aspect of shared decision-making is the environment, which is described as, "an environment in which the woman feels comfortable to provide candid contributions to the exchange of information," (Rothert & O'Connor, 2001, p. 310).

Decision aids are specific interventions or informational techniques used to assist patients to arrive at a healthcare decision. Decision aids usually involve an evaluation process of the patient's values, the options offered, and risk/benefit ratios (Rothert & O'Connor, 2001). Instruments that enhance decision-making are appearing in the literature as researched interventions in promoting patient-centered decision-making. Instruments have been developed in the form of patient educational material such as pamphlets, audiotapes, and counseling sessions. One tool developed by Col, Hirota, and Fortin (2000) used a risk assessment for hormone replacement therapy. Another example, the Comprehensive Health Enhancement Support System (CHESS) provides computer

based information about breast cancer for decision enhancement (McTavish et al., 1994). Each of the tools developed assist patients to take time and reflect on different aspects of their decision.

Weaver and Wilson (1994) provided a review of literature that supports patient involvement in decision-making and tests satisfaction about decision-making. The emphasis of this meta analysis was based on the need produced by the increased information explosion through advanced technology and the nature of diseases becoming more chronic than acute. These are predicted to lead the traditional medical model into new paradigms of patient involvement and empowerment (Fahrenfort, 1987; Fleming, 1992).

McNutt (2000) wrote a commentary about patient decision-making and decisional aids. He stated that decisional aids are needed to inform patients but that they are not adequate alone to support patients and ensure that they understand the true risk benefit ratios of their decision. He believed that satisfaction with the decision is unimportant because it reflects the effectiveness of the alternative. The major point of the commentary emphasized that it is the patient alone who should decide on a healthcare alternative (McNutt). Satisfaction with the decision is one outcome that may need to be assessed soon after the decision is made in order to prevent contamination of the results from consequences of the decision.

Rothert and O'Connor (2001) supported values as a critical component of decision-making and further stated that an effective decision is not only informed but acted upon. The authors also made a distinction between two types of decisional

evaluation, evaluating the decision process and evaluating the outcome of a decision. The outcome of a good decision does not necessarily have to turn out well and the outcome of a decision that was not thought out may in effect turn out favorable. Decisions about healthcare have been researched by measuring different outcomes including knowledge of the content, decisional conflict or uncertainty about the decision, and satisfaction. Satisfaction has been defined and measured with various instruments in studies as an outcome measure that can evaluate the decision itself, satisfaction with the decision, or satisfaction with the provider (Rothert and O'Connor). This article pinpoints the importance of differentiating if the patient is satisfied with the decision or the outcome.

Patient-centered decision-making was the topic of a National Women's Health Panel in 2001 and promoted informed woman decision-making as an essential component in women's healthcare. Mort (2001) recommended that the quality of decision-making for any common healthcare issue facing women needs improvement. Pearson (2001) collaborated on this theme by stating that decision-making calls for further exploration and acclaimed that it leads to shared accountability for both the practitioner and patient.

Decision-making theories and decisional science have explored the components within the decision-making process as well as developed tools for evaluation of outcomes of decisions. All decision-making theories assume a disruption in the individual's normal pattern that warrants a change that presents in possible alternatives. Knowledge is a strong component of the decision-making process and is needed to arrive at an informed and reasonable decision. Not all decision-making theories culminate in action or consider personal knowledge or the environment in which the decision occurs. Many theories

concentrate on the conflict that causes the decision, rather than the subconcepts needed to arrive at a decision. Satisfaction with the decision is continually mentioned as an outcome measurement but most authors warn of the need to differentiate satisfaction with the decision from the consequences of the choice (Rothert and O'Connor, 2001).

Decisional Science in Women's Healthcare

Women's healthcare issues have been explored by various decision-making theories. Research has been done by both qualitative and quantitative methods to better understand how women make decisions and why they chose specific alternatives. Warner (2001) warned against "gender mainstreaming" (p. 344) when focusing on the decision-making processes of women which means that women's decision-making should be looked at individually as well as collectively. The following qualitative research studies identify trends in women's decision-making while consideration is given to individual choice patterns.

Qualitative Studies about Decision-making in Women's Healthcare

Brown, Carroll, Boon and Marmoreo (2002) reviewed three separate qualitative studies about women's decision-making about healthcare issues to note common themes. One emergent theme was information seeking about the health issue. Another was information sources and their reliability. Informational sources were identified as social support networks, such as family and friends, professionals and independent research. The third prevalent theme identified was information sharing within the context of the professional relationship. Not all women perceived an open informational sharing. Accepting the consequences of the decision was another area of concern for participants.

The study summarized that personal values, along with past experiences, are an important factor in decision-making which are often minimized by health professionals. This study combined three studies to identify that information, dialogue and support systems are all variables in decision-making.

Boon, Brown, Gavin, Kennard and Steward (2000) studied women with breast cancer and their decision to use complimentary alternative medical treatment (CAM). Women with a wide age range (41 years to 73 years) were included in three focus groups ($N = 36$). One of the issues discussed in the focus groups was why women make the decision to use CAM ($n = 25$). Women who decided to use either herbal or dietary supplements as adjunct therapy expressed the need for guidance. Guidance was described as a “sounding board” using family and friends and in some cases, professionals. Other themes emerged related to risk/benefit ratios and those who chose to use CAM concentrated on the benefits while those who did not chose to use CAM ($n = 9$) believed the health risks were too great. This qualitative study again highlights the need for dialogue about decisions as well as information on outcomes of alternatives.

Sawka et al. (1998) developed a decisional aid for women with breast cancer who were presented with the choice of lumpectomy versus mastectomy. The aid was an audiotape and workbook and presented to two separate pilot groups ($N = 18$). Qualitative and quantitative data was collected during this study. Qualitatively, the women’s reactions to treatment options presented in the decisional aid, which included both explanation and pictures, were favorable. A value clarification exercise was included to determine the importance of options for each individual woman. Knowledge gained by

the decisional aid was evaluated with the revised Breast Cancer Information Test and an overall increase in knowledge was realized. The entire program was evaluated by the Decisional Conflict Scale (O'Connor, 1995) which scored responses on a 5-point Likert scale. On the scale, 1 represented low decisional conflict and 5 represented high decisional conflict. The mean overall scores for both pilot studies ($\underline{n} = 8$ and $\underline{n} = 10$) were 1.81 ± 0.31 (SD) and 2.2 ± 0.37 (SD), respectively. These conclusions supported previous results that patients score less than 2 after being informed, but above 2.5 if they delayed their decision. The patients in these small pilot studies were informed through the decisional aid materials but the results suggest that delayed decision-making increased stress. This study may suggest that information alone may not prove be enough to assist women in making decisions and that other components are needed.

Pierce (1993) used a qualitative method to describe decision-making used by women when selecting a mastectomy, lumpectomy, or adjunctive therapy for early-stage breast cancer. The study was conducted by semi-structured interview ($\underline{N} = 48$) and analyzed by constant comparative method. Five themes were described as decision behavior; perceived risk/benefits of alternatives, decisional conflict, information seeking, risk awareness, and deliberation. The participants were classified into three types of decision makers; deferrers (41%), delayers (44%), and deliberators (15%). The findings of this study support the role of information and include personal attributes as variables in decision-making. It also highlights individuality in the decision-making process.

Groff et al. (2000) researched women's beliefs and attitudes about the decision of having a hysterectomy. This qualitative study was done by interview. The women ($\underline{N} = 148$)

were from an inner city population and represented three distinct ethnic groups. Three themes emerged from the focus groups; the effect of male perception's about hysterectomies, the women's attitudes about physicians and the difficulty of the decision-making process. Women expressed a strong desire to become involved and to discuss their choice with important people in their lives lending support to social norms and reflection as important variables in decision-making.

Sowell and Misener (1997) studied HIV-infected women of childbearing age ($N = 22$) in relation to the process used in making reproductive decisions. Focus-group methodology was used with content analysis to uncover themes about pregnancy decisions. The subjects were from two rural southeastern states and the analyses revealed six major themes in making reproductive decisions; spiritual and religious beliefs, knowledge and beliefs about HIV, previous experience with childbearing, attitudes of families and sex partners, personal health, and intrapersonal motivation to have a baby. The decisions of this study group included taking into account personal and social variables.

Dempsey, Dracup and Moser (1995) used a qualitative method to describe the thought processes women use when making decisions to seek treatment for acute myocardial infarction (AMI). Using Grounded Theory methodology, the authors studied the pre-hospital experience of women ($N = 16$) diagnosed with AMI. Two major themes were identified; maintaining control and relinquishing control. Subcategories identified in this study were symptom awareness, perceived insignificance, self-treatment, perceived threat, and lay consultation. Decisions to seek treatment were influenced by the subject's

perceived ability to control the event. Participants often relied on self-treatment and minimized the importance of symptoms to maintain control. These coping mechanisms resulted in a delay of treatment. Consulting lay people (family and friends) was identified as an important factor in the women seeking healthcare.

Quantitative Studies about Decision-making in Women's Healthcare

Goel, Sawka, Theil, Gort, and O'Connor (2001) studied the effect of a decisional aid in audio booklet form on the decision-making process of women faced with lumpectomy versus mastectomy. The decisional aid contained a value clarification exercise (balance scale diagram), pictures, graphs and numbers. The control group was given the traditional pamphlet with the same basic information but without the visuals and value clarification exercise. Both groups were evaluated prior to intervention by the State-Trait Anxiety Inventory, The Breast Cancer Information Test-Revised (BCIT-R), and the Decisional Conflict Scale (DCS) for baseline data about perception and knowledge of breast cancer. There was no statistical difference in anxiety between the two groups ($n = 136$), one group with the value clarification packet and the other with the traditional pamphlet ($p = .43$). Value clarification alone was not effective in reducing anxiety in the well constructed quantitative study with a sufficient number of subjects.

O'Connor et al. (1999) researched values in relation to decision-making in a randomized controlled study involving subjects deciding on hormone replacement therapy ($N = 201$). Those that used a value clarification weigh-scale, had no significant difference ($p = .06$) in congruence about their choices than the control group who were not exposed to a value clarification exercise with their decisional aid. Value clarification

needs further investigation for its importance in decision-making and may need different methodologies, such as reflection or evaluation of personal knowledge, to significantly impact decision-making.

Legare et al. (2003) described the current science involving shared decision-making as part of the paradigm of patient-centered medicine which recognizes the patient as an active participant in healthcare decisions. The Ottawa Decision Support Framework (ODSF) has provided key research to prepare patients and physicians for shared decision-making. The ODSF determines subconcepts of decision-making such as determinants of decisions, decision support interventions, and evaluation of the effect of the decision support by measuring the quality of decision-making. Legare et al. purpose that theoretically improved decision-making should improve patient outcome. Decisional conflict is defined within this framework as subjective experience of the individual which is influenced by knowledge, expectations, values, norms, pressure, support, and resources. These are consistent with the subconcepts being explored in the Wittmann-Price Theory of EDM.

The Legare et al. (2003) study evaluates a decisional aid, about HRT, and its effect on patients and physicians. Demographic data was collected on both physicians ($n = 40$) and patients ($n = 194$). The decisional conflict scale (DCS) was administered to patients before they were assigned to groups using the decisional aid or a pamphlet. The DCS has a coefficient of .78. The Dolan's Provider Decision Process Assessment Instrument (PDPAI) (Cronbach alpha = .90) was administered to the physicians to determine their decisional conflict and perception of the woman's choice. The physicians

were also assigned to a decisional aid group or pamphlet group. The DCS and the PDPAI were measured by the weighted k coefficient (ICC) and two-way random ICC then compared by Student's t -test. All values of weighted $k = .40$. The DCS mean score for the decisional aid group was 2.1 and 2.2 for the pamphlet group. The PDPAI mean score was 2.1 for the decisional aid group and 2.2 for the pamphlet group. The agreement between physicians and patients was not significant ($p = .32$) but this was the first reported study of physician and women assessment of decisional conflict. This study supports the previous studies that pen and paper value clarification may not be an effective way to decrease decisional conflict.

Results showing the importance of social influence on a decision were obtained by Andrist (1998) when researching the impact of specific variables of women's decision to use hormone replacement therapy (HRT). Andrist interviewed a sample ($N = 21$) of well-educated European American women (42 to 53 years) to explore how women make decisions about HRT for natural menopause. The study revealed the strongest impact on decision-making in all three groups was the media. The three groups included, those taking HRT, those opposed to HRT treatment and those undecided groups. This finding may supports social norms as an important decision-making influence since the media is so intricately woven into our society.

Rothert et al. (1997) also studied decision-making in reference to menopausal women. This large study ($N = 248$) used three separate decisional support interventions (DSI) over a 12 month period to evaluate knowledge, decisional conflict, satisfaction with healthcare provider, and self-efficacy. Knowledge of menopause was measured by a

multiple choice and true/false scale specifically developed with an alpha = .85. Decisional conflict was measured with the Decisional Conflict Scale (DCS), and the Satisfaction with Decision Scale (SWD). A satisfaction scale was used to measure satisfaction with the healthcare provider. A third instrument, a self-efficacy scale, measured that variable. Behavior and adherence was measured by the woman's own plan. The interventions consisted of written instruction, guided discussion or a decision exercise. The results revealed an increase knowledge over time in all three groups ($r^2 = .34$, $F(3,747) = 554.6$, $p < .05$). Decisional conflict decreased over time ($F(2,498) = 27.08$, $p < .05$). There were no significant differences in satisfaction between groups ($F(2,498) = 5.36$, $p < .05$). Satisfaction with healthcare provider increased over time significantly ($F(2,498) = 17.75$, $p < .05$). Self-efficacy increased in each group over time but there was no statistical significance between groups ($t = 11.30$, $p < .05$). This study suggests that information and reinforcement of information can be given in a variety of ways to benefit decision-making and conflicts with the findings of other studies (Sawka et al., 1998).

Drake, Engler-Todd, O'Connor, Surh, and Hunter (1999) discussed decision-making in relation to women's choices about prenatal testing. A decisional aid, based on a modification of a previous aid developed by O'Connor (1995), was used. The content of the decisional aid was developed by experts and consisted of a workbook, audiotape and worksheet which was pilot tested with 12 participants. After the intervention, women ($n = 21$) and spouses ($n = 17$) were found to have significantly higher knowledge ($p < .001$) about the issues. Decisional conflict was measured pre and post intervention and

revealed a significant decrease in all areas of decisional conflict with the exception of the certainty subscale. The most marked reductions in measured decisional conflict were in the subscales of values and information. The decisional aid did not reduce trait anxiety as measured pre and post intervention by the Spielberger State-trait Inventory. After intervention the decisional predisposition measure revealed fewer participants were considering prenatal testing as an option for advanced maternal age. This well formulated study statistically supports that information is important for decision-making and value clarification may also be an issue encompassed in decision-making.

Erci (2003) studied the efficiency of the decision-making process of women who used a perinatal clinic in Turkey as well as their perception of their family position. Demographic data was also collected by inquiry ($N = 300$). The results showed a positive correlation in decision-making and perception of status in the family ($\chi^2 = 35.25$, $df = 15$, $p < 0.01$). Overall, results revealed that in this population, men made more of the decisions with the exception of decisions about clothing. This study is specific to a narrow socio-cultural context but the correlations may be applicable once tested in other populations and it suggests that social norms are a strong influence on decision-making.

Decision-making issues surrounding voluntary termination of a pregnancy were researched by quantitative methodology by Faria, Barrett and Goodman (2001). A questionnaire was used to collect data at two out-patient abortion clinics in South Central Kansas. The questionnaire was developed specifically for this study and pilot tested. The first subscale measuring general attitude had a Cronbach Alpha of .75 and the second subscale measuring subjects' feelings had a Cronbach Alpha of .73. A positive general

attitude about abortion measured by the first subscale correlated positively to white subjects as compared to non white ($t = 5.52$, $df = 112.76$, $p = < .001$), Protestants as compared to non Protestants ($t = 2.50$, $df = 394.87$, $p = < .01$), older subjects as compared to younger women ($t = -2.11$, $df = 470.85$, $p = < .04$), women with higher educational levels ($t = -3.45$, $df = 510.58$, $p = < .001$), increased income ($t = -2.14$, $df = 431.43$, $p = < .03$) and those women that used contraception ($t = -3.28$, $df = 523.15$, $p = < .001$). The second subscale used to measure the subjects feelings about their decision had an overall $M = 2.74$ on a five-point Likert Scale with a standard deviation of .66. The only significant demographic variable for positive feelings about the abortion decision was race. Non white subjects were more positive than white subjects ($t = 2.45$, $p = < .02$). Seventy-two percent of the non random sample ($N = 517$) sought help through discussion from a friend or physician and less often from family in regard to their abortion decision. There was no significant difference for age, race, income, education and contraception use between the group of women that sought professional counseling about their decision and those that did not. Discussion of the alternatives was a strong indicator of decisional outcome and a component included in decision-making.

Newton et al (1997) conducted a large quantitative study ($N = 1082$) to examine health practices in older women (aged 50 to 80) using computer-assisted telephone interviews. The authors investigated the decisional reasons for initiating, discontinuing, or not initiating (HRT). The most frequent reasons users gave for taking HRT were; relief of menopausal symptoms (47.3%), to prevent osteoporosis (32.4%), and because of physician advice (30.3%). The most frequently cited reasons for stopping HRT were;

uncomfortable side effects (26.6%), physician's advice (22.9%), fear of cancer (15.4%), and not wanting menstrual periods or bleeding (15.2%). The most common reasons for women never starting HRT were; they felt they were not needed (49.9%) or that menopause is a natural event (17.9%). The results of this study suggest that many women decided about HRT without consulting healthcare providers. This study but did not specify the origin of the information gathering from other sources.

Petrissek, Laliberte, Allen, and Mor (1997) investigated decision-making in relation to age and breast cancer options ($N = 179$). This retrospective study was done by self-report on a non-probability sample. Decision-making style varied with age in this sample of breast cancer patients. The bivariate analyses determined that older women (aged 70 years and older) were significantly more ($p < .05$) likely to be satisfied with the knowledge given by the physician while younger women (aged less than 50 years) wanted more information before choosing a treatment for breast cancer ($p < .001$). Younger women were also more likely to seek a second opinion ($p < .001$) and consulting three or more physicians about treatment ($p < .01$) declined with age. Younger women were also more likely to seek information through informal means such as asking questions and consulting with family and friends ($p < .05$). A multivariate analysis was done for all dependent demographic measures but the results were not shown. This study adds to the body of literature that demographic variables, such as age, may influence the decision-making process as well as information about the alternatives and discussion with significant people.

Summary of Decision-Making in Women's Healthcare

The studies reviewed, demonstrate women's decision-making in relation to various healthcare choices or treatments. The studies suggest different variables are important to the decision-making process for women collectively, yet note that demographic variables can produce individual differences. The decision-making process often includes the influence of non-professionals such as family, friends and the media (Andrist, 1998; Boon et al., 2000; Dempsey et al., 1995; Groff et al., 2000; Petrisek et al., 1997). Information gathering was an element of many of the decision-making studies described (Griffiths, 1999; Petrisek et al.; Pierce, 1993; Sowell & Misener, 1997). Personal attributes such as level of education (Erci, 2003), age (Petrisek et al.), and personality traits (Griffiths; Pierce) were some of the demographic variables implicated in effecting decision-making. The variables identified in these studies support the subconcepts, empowerment, personal knowledge, reflection, social norms and flexible environment being explored in the Wittmann-Price Theory of EDM.

Decision-making Applied to Non Gender Clinical Care

Some of the decision-making variables that have been studied in women's health issues have also been studied in healthcare decision-making by both genders. Many of the same issues may be applicable to men and women although the Wittmann-Price Theory of EDM in women's health identifies social norms as having a different impact on women making decisions about healthcare issues. Decision-making in non gender specific healthcare situations has been studied qualitatively and quantitatively and are reviewed in the following section. These studies are important to review to conceptualize decision-making on a larger scale.

Stacey, Jacobson and O'Connor (1999) promoted the Ottawa Decision Support Framework (ODSF) based on the assumptions that there is no clear choice that is right for everyone. They noted that decisions are stimulated by new diagnosis or life transition and decisions require careful deliberation because they are value-laden and have risk-benefit trade offs. They suggest that the deliberation process to make a decision requires more effort than the actual implementation of a decision. The ODSF framework was built on these assumptions and has a three step process; 1.) assessing the options of a decision to determine needs, 2.) providing support to meet those needs, and 3.) evaluating the decision-making process. The decisional framework developed by O'Connor et al. (1999) is based on theoretical components from general and social psychology, decision analysis and conflict, social support and economics and correlates with the assessment, intervention and evaluation phases of the nursing process. This framework, and the instrument developed, is part of a large scale Canadian study which has prompted many initiatives to develop and validated new instruments (Bunn, O'Connor, Tansey, Jones & Stinson et al, 1997; Mitchell, Teto & O'Connor, 2001).

The Decisional Conflict Scale (DCS) (O'Connor, 1995) was used, in modified form, in a study of schizophrenia patients (Bunn, O'Connor, Tansey, Jones & Stinson, 1997) when faced with uncertainty about continuing depot neuroleptic medication. Along with the DCS, self-efficacy was evaluated with the Decisions Self-efficacy Scale (DSES) and the Decision Emotional Control Scale, both developed by O'Connor (1995). Both of these scales were also modified to meet the evaluative needs of the psychiatric population (N = 96). The total group scores were compared between those who chose to continue

treatment ($n = 82$) and those who were uncertain ($n = 9$). The patients who were uncertain reported higher decisional conflict ($M = 29.8$ compared to 20.9 , $F = -6.73$, $p < .00$) and lower decisional self-efficacy ($M = 16.8$ to 14.6 , $F = -2.29$, $p < .037$) and decisional emotional control scores ($M = 9.7$ compared to 6.6 , $F = -3.89$, $p < .003$). The results of the study imply that this group of patients was willing to make decisions about their treatment and enhance their self-care. The role of the nurse is discussed in this context as supportive and educative in involving patients in treatment decision-making.

A decisional aid, using information in the form of audiotape and booklet, was also devised for Substitute Decision-Makers (SDM) taking care of cognitively impaired older patients. The Decisional Conflict Scale (DCS) was administered pre and post decisional aid intervention. The specific clinical context was the continuation or discontinuation of tube-feeding. The score for the DCS significantly decreased after significant others had exposure to the decisional aid (2.29 ± 0.52 (SD) compared to 2.88 ± 0.62 (SD), $p < .004$). Qualitatively, the majority of participants found the decisional aid helpful, clear and appropriate when making decisions in a substitute capacity for loved ones (Mitchell, Tetoe & O'Connor, 2001). This study demonstrates that the healthcare decision-making principles can be applicable to care givers of dependent patients.

Man-Son-Hing et al. (2002) investigated patient decision-making through both qualitative and quantitative methodologies when presenting risk estimates about stroke to patients in decision aids ($N = 198$). The decision aid provided risk information and treatment possibilities. Methodology used in patient education has been controversial in how assistive each type is in helping a patient arrive at a decision. The study was done by

using a 2 X 2 factorial design. The decisional aid was presented in audiotapes, booklet and worksheet form in both qualitative and quantitative versions to low and moderate risk groups. The patients were volunteers and randomly assigned. Outcome was measured by the Decisional Conflict Scale (DCS), their choice of therapy, a rank-ordered stroke risk evaluation tool, a test for knowledge acquisition, and measuring their expectations of the chances for stroke if treatment was disregarded. The DCS revealed no statistical difference in outcome between the qualitative and quantitative groups ($p = .89$) by t-test and chi square analysis. Those participants that were assigned to a moderate risk group showed a statistical difference in treatment choice ($p < .01$). There was no statistical difference in the rank-ordering of stroke chance between the two groups ($p = .10$) and knowledge acquisition also showed no statistical difference ($p = .64$). There was a statistical difference for the measurement of stroke expectations from the quantitative group. This may have been predicted since the subjects were provided with the exact numerical probability of future stroke incidence. In comparing decisional aids with qualitative and quantitative data in this volunteer population, the expectations of stroke risk, when presented in numerical findings, benefited patient decision-making. This study supports the need for professional health information in the decision-making process.

Fiset et al. (2000) studied the evaluation of a decisional aid for non-small cell lung cancer patients in stage IV. The study purpose was to incorporate patients values in the decisional aid ($N = 20$). The decisional aid was comprised of three subscales; knowledge, decisional conflict and value clarification. The results revealed that it significantly improved their knowledge about options and outcomes ($p < .001$) and

decreased decisional conflict ($p < .01$). The decisional aid provided information on options, guided the patient in the steps of decision-making and included a weigh-scale exercise to elicit personal values. After patients used the decisional aid, knowledge increased and decisional conflict significantly decreased ($p < .01$). The value exercise revealed that most participants preferred an active role in decision-making and felt clearer about what was most important for them after information was provided. The variables identified in this study, value clarification and personal values, support EDM. The sample was small but the study well controlled and findings significant.

Dales, O'Connor, Hebert, Sullivan, McKim, and Llewellyn-Thomas (1999) studied decision-making of chronic obstructive pulmonary disease (COPD) patients who were faced with mechanical ventilation (MV) as a treatment for a respiratory crisis. The investigation was initiated because disparities were observed between the patient's wishes and the physician and family's choice during times of respiratory crises when the patients were unable to advocate for themselves. The researchers pointed out that the information provided by health professionals may have been slanted due to their reluctance to deal with end of life issues and this placed pressure on the patient to arrive at the alternative that was most comfortable for the professional. In order to study this decision-making conflict, the authors developed a decisional aid about MV in the format of an audiotape with an accompanying booklet. The decisional aid, once validated, was piloted using a convenience sample ($N = 20$). Data collection was done through the use of two interviews and the Short Portable Mental Status Questionnaire to verify cognitive ability of decision-making. Patients were surveyed about their preference for MV, before

and after, the decisional aid were reviewed. The Decisional Conflict Scale (DCS) was also administered to determine the amount of conflict MV would cause the patient. The patients were asked about their decision one year later and compared their initial decision and the preferences of their physicians ($n = 6$) and family members. There was a significant ($p < .05$) shift in participants changing their decision about MV when analyzed by t-test. The participants had a low DCS of 2.2 on a scale of 0-5 with a SD of 0.9. Decisional stability was reported high for one year (89% would not change their decision). Sixty-five percent of physicians agreed with the decision of the participant and, of seven family members that were interviewed, none of their preferences matched the participant to whom they were related. This study underscores the important implication that people in a patient's life may have different decisional expectations than that of the patient. These different expectations may suggest that decision-making needs to be looked at from both a personal and social perspective.

Summary of Decision-making Applied to Non Gender Clinical Care

The preceding studies highlight the development of decisional-aid tools for specific patient populations as useful interventions in the decision-making process. Decisional tools are aids and can be implemented with the patient, family members or both as adjunctive therapies to individual decision-making. The tools include important variables in decision-making including estimation of risk/benefit and value clarifications and support the variables being explored in the Wittmann-Price EDM Theory. The study by Dales et al. (1999) is of particular interest because it considers the decisions of patients and family may differ even when intentions are health promoting.

Infant Feeding Method Decisions

Introduction

Deciding to breastfeed, as well as continuance of breastfeeding, has generated the majority of nursing research about infant feeding methods. Industrialization in developed nations has made breastfeeding an alternative rather than a necessity for infant survival. Due to the recent discovery of immunological benefits identified in breast milk, the American Academy of Pediatrics (AAP) (2005) recommends that all mothers breastfeed their infants for the first year of life. The benefits cited are numerous and include a decreased incidence of bacterial meningitis, bacteremia, diarrhea, respiratory tract infection, necrotizing enterocolitis, otitis media, urinary tract infection, and late-onset sepsis in preterm infants, sudden infant death syndrome, diabetes mellitus, lymphoma, leukemia, and Hodgkin disease, obesity, hypercholesterolemia, and asthma (American Academy of Pediatrics, 2005).

There are multiple variables that enhance or deter a women's decision to initiate and continue to breastfeed. These variables have been extensively reviewed in the literature and include age, socioeconomic factors, nipple soreness, time of initiation, and prenatal teaching, among others (Arbon & Byne, 2001; Dennis, 2004). The studies researching these variables will be cited in the remaining part of this chapter. Some studies have approached the decision about infant feeding method from a theoretical point of view using behavioral theories. These will also be reviewed as pertinent to the decision to breastfeed.

Few articles have been recently published advocating bottle feeding or breastfeeding with supplement. The advantages of bottle feeding are often extracted from the disadvantages in the breastfeeding literature. Those that have been published as directly advocating bottle feeding have solicited an onslaught of public and professional criticism (Gigliotti, 1998). These will also be reviewed because they reflect an alternative that is currently unpopular according to social norm. A list of intrinsic and extrinsic variables studied in women, identified from the literature, as affectors about choosing a specific method of infant feeding is presented in Table 1. Intrinsic factors are those perceptions that the woman is choosing a feeding method based on infant outcome and the intrinsic factors are those factors considered by the woman based on her perception of her own outcome (Wells, Thompson, and Kloebler-Tarver (2002).

Several studies explore intention, a component of decision-making, about infant feeding through behavioral theories. Bandura's Social Learning Theory, Transtheoretical Model (TM), Theory of Planned Behavior and Ajzen and Fishbein's Theory of Reasoned Action (TRA) have been successfully used to explain specific aspects of why a person may choose an alternative and what is needed to follow up and implement the alternative. Many of the theories integrate change theory, motivation and self-perception as important variables in carrying out a decision. The TM model includes five stages that include 10 processes of change. The stages include pre-contemplation, contemplation, preparation, action and maintenance which all assist a person to get ready for change. The 10 processes are behavior activities that support the stages. The theory also includes decisional balance that is a weighing of the positive and negatives of an alternative as

Table 1. Variables identified in the literature as affecters of feeding method decision-making.

Factors that influence or support women to breastfeed	Reference	Factors that influence or support women to bottle feed	Reference
<u>Intrinsic Factors</u>			
Commitment to succeed	Bottenroff, 1990.	Maternal medical reasons	Matthews et al., 1998.
Guilt expressed by mother if not breastfeeding	Bean, 2001; Earle, 2000; Hauck & Iruita, 2003; Lothian, 1998; Mozingo, Davis Droppelman & Merideth, 2000.	Maternal smoking	Matthews et al., 1998.
Timing of decision about feeding method	Hill, 1988; Kieffer, Welch & Thiele, 1997; Oxby, 1994.	Bad previous experience	Matthews et al., 1998.
Attitude about feeding method	Dix, 1991.	Not comfortable	Matthews et al., 1998.
Idealized expectations (level of difficulty) about breastfeeding	Hannon et al., 2000; Hawkins & Heard, 2001; Mozingo et al., 2000; Hauck & Iruita, 2003.	Too demanding	Matthews et al., 1998.
Mother's health issues that are promoted by breastfeeding such as involution of the uterus as a reason to chose breastfeeding	Dix, 1991.	Preferred not to	Matthews et al., 1998; Norton, 1998.

(table continues)

Factors that influence or support women to breastfeed	Reference	Factors that influence or support women to bottle feed	Reference
Convenience and scheduling of feedings	Dix, 1991; Hawkins & Heard, 2001; McIntyre, Hiller & Turnbull, 2001.	Perceived lack of milk when breastfeeding	Barber et al., 1997.
Educational level of mother	Matthews et al., 1998.	Modesty concerning breastfeeding	Raisler, 2000.
Prior feeding experience	Dix, 1991; McIntyre, Hiller & Turnbull, 2001; Meyerink & Marquis, 2002; Milligan et al., 2000.	Feeling tied down with breastfeeding	Raisler, 2000.
Preference for one feeding method over another	Matthews et al., 1998; Williams et al., 1997.	Anxiety or depression	Milligan et al., 2000; Pugh, Milligan & Brown, 2000.
Maternal medical issues	Dix, 1991.		
Distaste about one feeding method	Matthews et al., 1998.		
Ethnicity	Ford & Lobbok, 1990; Williams et al., 1997.		
Bonding enhancement	Hawkins & Heard, 2001; Lothian, 1994.		

(table continues)

Factors that influence or support women to breastfeed	Reference	Factors that influence or support women to bottle feed	Reference
Parity	Barber et al., 1997; Kieffer, Welch & Thiele, 1997; Meyerink & Marquis, 2002; Milligan et al., 2000.		
Maternal comfort when breastfeeding	Hawkins & Heard, 2001; Matthews et al., 1998; McIntyre, Hiller & Turnbull, 2001; Mozingo et al., 2000; Pugh, Milligan & Brown, 2000.		
Cultural norms	Barber et al., 1997; Dodgson & Struthers, 2003; Higginbottom, 2000; Lothian, 1994; Zinn, 2000.		
Sleep disturbances related to a feeding method	Milligan et al., 2000; Pugh, Milligan & Brown, 2000.		
<u>Extrinsic Factors</u>			
How the mother herself was fed as an infants	Dix, 1991; Meyerink & Marquis, 2002.	Wanted father more involved.	Matthews et al., 1998; Norton, 1998.
			(table continues)

Factors that influence or support women to breastfeed	Reference	Factors that influence or support women to bottle feed	Reference
Maternal age	Matthews et al., 1998; Milligan et al., 2000.	Not encouraged to by family, friends, or spouse.	Matthews et al., 1998.
Prenatal education	Coombs et al., 1998; Giugliani et al., 1994; Handfield & Bell, 1995; Lothian, 1998; Martens, 2001.	Early postpartum difficulties	Matthews et al., 1998.
Infant health factors	Alexy & Martin, 1994; Dix, 1991; Hawkins & Heard, 2001; Lothian, 1994.	Convenience	Matthews et al., 1998; Norton, 1998.
Premature delivery	Meyerink & Marquis, 2002.	Returning to work	Matthews et al., 1998; Norton, 1998.
Professional help in learning to breastfeed	Barrowclough, 1997; Hawkins & Heard, 2001; Hoddinott & Pill, 2000; Martens, 2002; Mozingo et al., 2000; Raisler, 2000; Williams & Pan, 1994.	Hospital routine	Hawkins & Heard, 2001.
Early hospital discharge	Margolis & Schwartz, 2000.	Hospital discharge packs containing formula	Dungy et al., 1997; Howard, Howard & Lawrence, 2000.

(table continues)

Factors that influence or support women to breastfeed	Reference	Factors that influence or support women to bottle feed	Reference
Socioeconomic status	Matthews et al., 1998; Williams & Pan, 1994.	Employment or school	Morse & Bottorff, 1989; Raisler, 2000; Rodriquez-Garcia, 1990; Williams, Innis, Vogel & Stephen, 1997.
Cost of bottle feeding	Hawkins & Heard, 2001.	Breastfeeding in public	Libbus, 1992; McIntyre, Hiller & Turnbull, 2001; Sheeshka et al., 2001.
Male partner support for a specific feeding method	Dix, 1991; Hill, 1988; Giugliani et al., 1994; Lothian, 1994; McIntyre, Hiller & Turnbull, 2001.		
Father's involvement in feeding method	Earle, 2000; McIntyre, Hiller & Turnbull, 2001; Lothian, 1994.		
Family and friend (non-professional) support for breastfeeding	Alexy & Martin, 1994; Barber et al., 1997; Chezem, Friesen & Clark, 2001; Duddridge, 2000; Giugliani et al., 1994; Hannon et al., 2000; Hill, 1988; Libbus, 1992; Lothian, 1994; McIntyre, Hiller & Turnbull, 2001; Milligan et al., 2000; Williams & Pan, 1994.		

well as investigating self-efficacy. Self-efficacy is a situational confidence that the person has about being able to perform a behavior (Humphreys, Thompson & Miner, 1998). TRA states that intention determines behavior and intention includes attitudes and social norms.

The four theoretical constructs that have been used to explain human feeding behavior are organized in Table 2. All of the theoretical constructs partially explain human behavior and motivation related to feeding method choice. The transtheoretical model (TM) supported a change theory in an adolescent population in relation to increasing breastfeeding rates. Social support, attitude and self-efficacy were significant variables. The Theory of Reasoned Action, which includes attitude and social norms as constructs of intention to perform a behavior and as determining factors in carrying out that behavior, has been supported as a theoretical model for feeding method (Manstead, Proffitt & Smart, 1983).

Breastfeeding Literature

Wells, Thompson and Kloeblen-Tarver (2002) studied the intrinsic and extrinsic factors used by mothers in deciding feeding method. The authors used cognitive evaluation theory as the basis for their study ($N = 228$). The study investigated breastfeeding and bottle feeding motivation through a questionnaire compared by factor analysis. The cognitive evaluation theory defined motivation as being intrinsic or extrinsic. Intended breast feeders were shown to have both, higher intrinsic and extrinsic motivational factors, significant at the $p = \leq .001$ level. Much of the research done about

breastfeeding has been spurred by the discrepancies in expected rates of initiation of breastfeeding in relation to established national health goals, in order to decrease the gap.

Table 2.

Theoretical constructs used in feeding method studies.

Theory	Major paradigm	Research studies
Transtheoretical Model (TM)	5 stages and 10 process of change. Stages include pre- contemplation, contemplation, preparation; action and maintenance to get ready for change. 10 processes are behavior activities which support the stage.	Humphreys, Thompson & Miner, 1998.
Theory of Reasoned Action (TRA)	Reasoned action theorizes that actual behavior is determined by intention which includes both attitudes and subjective norms.	Manstead, Proffitt & Smart, 1983.
Theory of Planned Behavior (TPB)	Behavior is determined by intention and ability.	Duckett et al., 1998; Swanson, & Power, 2005; Wambach, 1997.
Bandura's Social Learning Theory (self-efficacy)	Perception of confidence in oneself.	Bottorff, 1990; Kessler et al., 1995.

Much of the research has focused on the reasons women do not breast feed. The following studies review those issues and are organized according to general variable being analyzed as it related to the Wittmann-Price Theory of EDM.

Empowerment through Professional Knowledge

Personal choice was a factor investigated in two studies (Mathews, Webber, McKim, Banoub-Baddour & Laryea, 1998; Williams, Innis, Vogel & Stephen, 1997). The Mathews et al. study classified personal choice as a type of embarrassment about breastfeeding while the Williams et al. study compared personal choice to professional information given by physicians. The women that were given professional information were more likely to attempt to breastfeed. The Williams et al. study implicates professional knowledge as an important variable in the decision-making process while the Mathews et al. study suggests that personal perception is also influential.

A retrospective multicultural study done in Hawaii by Kieffer, Welch, Mor, and Thiele (1997) suggested that women were more likely to breastfeed when the decision was discussed during the prenatal period. This indicates that the time period in decision-making may also be an important variable.

Wells et al. (2002) showed that intrinsic factors were more important to breast feeders than bottle feeders. This was supported in the Alexy and Martin (1994) study. The health of the infant as a motivator for breastfeeding was significant. A quantitative study conducted by Dix (1991) also suggested the infant's health as a motivator to choose breastfeeding. Knowledge about the benefits of breastfeeding for infant health is directly related to empowerment by professional knowledge derived from scientific investigation.

A study conducted by Raisler (2000) on low-income women found that potential professional support by WIC (Women, Infants and Children) staff actually increased the breastfeeding rates in low income women. Coombs, Reynolds, Joyner, and Blankson

(1998) found that programmed instruction about breastfeeding and its benefits increased ($p = .04$) breastfeeding rates among low income women ($N = 151$) when instituted during the prenatal period. Slightly over 60% of the treatment group that received prenatal self-help manual instructions left the hospital breastfeeding compared to 43.6% of the control group. This study strongly supported professional knowledge as an influence in supporting one type of feeding method over another.

Environmental Factors

Professional advice was viewed as both part of the social context and as an environmental factor. Nurses were in a better position to advocate for breastfeeding, as a method of choice, when education about breastfeeding was provided to the nursing staff (Martens, 2002). Regardless of education, attitude was correlated as a strong variable compared to the nurses' intentions (Bernaix, 2000; Martens, 2001). In a social context, professional opinion and advice were not as influential as family and friends (Raj & Plichta, 1998). Hoddinott and Pill (2000) reported women's perception of postpartum nurses. This study found that women perceived professionals as not proactive in encouraging breastfeeding on the postpartum hospital unit.

Bernaix (2000) studied maternal child health nurses ($n = 50$) and breastfeeding mothers ($n = 136$) in a prospective investigation guided by TRA as a framework. The study revealed that the nurses' intention to provide breastfeeding support was best predicted on the variables of attitude and social pressure when measured by a questionnaire. The study did not find a direct correlation between intention and behavior on part of the nursing staff; therefore, it did not fully support the theoretical assumptions

of the theory of reasoned action. It was determined that knowledge and attitude were better predictors of actual behavior than intention. Intention was not clearly defined in this study.

Personal Knowledge Factors

Handfield and Bell (1995) studied the effects of childbirth education classes on mothers' feeding choice. They found that most women had made their feeding decision prior to attending class. Childbirth education classes were not successful in persuading mothers to change their infant feeding decision. Dix (1991) also found that 50% of mothers made their feeding method choice preconceptually. Oxby (1994) substantiated those results by investigating when feeding choices were made and also showed that few mothers changed their minds about feeding methods later in pregnancy. Only 18% of the sample ($N = 67$) were undecided at the time of their delivery about feeding choice and of those women who had decided (82%), only 11% of the intended breast feeders switched to bottle and only 5% of the bottle feeders switched to breastfeeding (Oxby, 1994). The Oxby study was well constructed with a large sample.

Reflection

Duckett, Henly, Avery, Potter, Hills-Bonczyk, Hulden et al. (1998) also used the TBP to investigate the variability in breastfeeding intention and duration among three groups of mothers; those not working, those working part time, and women who were working fulltime ($N = 635$). Thirteen variables were used in the equation to test attitude, perceived control and subjective norm. In the unemployed ($n = 180$) and part time working groups ($n = 110$) perceived control and attitude toward breastfeeding were

stronger correlations to intent than subjective norm. Breastfeeding intention was strongly correlated ($p < .05$) to breastfeeding duration in all groups. A surprising variable “perceived insufficient milk supply” was significant ($p < .05$) in all groups and is a phenomenon poorly understood in the United States. This study was done with a homogenous group of Caucasian subjects which suggests the need for replication with more diverse populations.

Humphreys, Thompson and Miner (1998) evaluated breastfeeding intention using the Transtheoretical Model (TM) and Ajzen and Fishbein’s Theory of Reasoned Action (TRA). Data were collected by a self-administered, author made instrument, comprised of 70-items. The instrument measured five discrete concepts; decisional balance (TM) and attitudes toward breastfeeding (TRA) ($\alpha = .79$), the 10 processes of change (TM) ($\alpha = .83$), subjective norms (TRA) ($\alpha = .67$), and stages of breastfeeding (TM) and breastfeeding intention (TRA) ($\alpha = .79$). There was significant correlation between the stages of change for breastfeeding (TM) and breastfeeding intention (TRA). Results identified a significant ($p < .01$) positive correlation between stages of change for breastfeeding scored by the TM scale and attitudes toward breastfeeding, collected on the TRA scale. All constructs measured with both theories were significantly correlated. As the stages of change increased (TM), so did subjective norms (TRA) ($r = .34$, $F [1,894] = 115.23$, $p < .01$) and as the stages of change increased, so did attitudes towards breastfeeding (TRA) ($r = .50$, $F [1,741] = 243.69$, $p < .01$). A factor analysis was done between the 20 items on the TM model which was designed to investigate 10 processes of change. The factor analysis revealed 9 out of 10 factors loaded for the 10 processes of

change when factor with Eigenvalues of greater than 1.00 were retained. Interestingly the two items that did not load on any factor were those labeled “self-liberating”. This result may indicate that liberation and emancipation are different concepts or they may be concepts difficult to operationalize. The two factors that did not correlate were labeled “self-liberation process” and were stated in the following manner:

“I tell myself I can choose to breastfeed or not.”

“I tell myself I am able to breast feed if I want to.”

The Theory of Reasoned Action (TRA) was also used by Manstead, Proffitt, and Smart (1983) to investigate attitudes and subjective norms associated with breastfeeding intention. The research reported a positive correlation ($r = .77$) between intention and behavior and when the subjective norms are regressed on the equation the correlation revealed more significance ($p < .001$). Primiparas and mutiparas were compared for intention and subjective norms through questionnaires before and after delivery ($N = 215$). The multiple correlation analysis of the attitudinal and normative components with infant feeding accounted for the majority of the variation in intention. These factors counted for the majority (59%) of the variation thereby supporting the TRA although attitudinal factors were slightly better predictor for multiparas. Reasoned action theorizes that actual behavior is determined by intention which includes both attitudes and subjective norms. This supports development of an emancipated decision-making model to further define subjective norms.

Kessler, Gielen, Diener-West, and Paige (1995) compared Ajzen and Fishbein’s Theory of Reasoned Action (TRA) and Bandura’s Social Learning Theory (Bandura,

1986) as possible explanation of women's intentions to breastfeed in a stratified population sample ($N = 491$). Independent variables were categorized in the framework of Bandura's Social Learning Theory. Interviews were conducted with participants and significant others by phone ($n = 133$). "Significant others" were defined as a male partner, family member or friend who was involved in the woman's decision to breastfeed. Results suggested that significant others' knowledge and preferences were influential in the women's decision. This study supported including significant others in prenatal education concerning breastfeeding and using peer counselors as supported by Federal and state WIC efforts. The investigators concluded that intention to breastfeed can be predicted from the Theory of Reasoned Action coupled with the concept of self-efficacy from Bandura's Social Learning Theory. Social learning theory suggests that behavior is determined from four processes including; cognitive processes, incentives and reinforcers, social modeling and self-efficacy. Self-efficacy is viewed as women's confidence in their abilities to initiate and sustain breastfeeding. This study was well done with an excellent subject number and well defined variables.

Self-efficacy as an attribute of attitude has been studied in several investigations including that of Bottorff (1990), which found a qualitative thread of self-determination as an intrinsic factor. Kessler et al. (1995) also suggests that self-efficacy is a strong indicator of breastfeeding as a choice. Self-efficacy may be related to the woman's personal knowledge about herself and therefore her perceptions of her capabilities.

Social Factors

The need for the majority of mothers to return to work is a prevailing factor in

industrialized societies when choosing a feeding method (Morse & Bottorff, 1989).

Women of lower income status tend not to choose breastfeeding as an option (Lawrence, 1991). Another factor that correlates with choosing breastfeeding includes the history of the women being breastfed as an infant. Also a woman is more likely to breastfeed if she had breastfed another infant (Dix, 1991; Meyerink & Marquis, 2002).

The social support of individuals significant to the women deciding on infant feeding method is an important variable and the topic of numerous studies. Significant others are defined differently in various studies and include a variety of people who have an impact in the woman's life. These have included people defined as the father of the baby or present male partner, the woman's mother, the woman's grandmother and close relatives and friends (McIntyre, Hiller & Turnbull, 2001). Hill (1988) determined that a woman's mother was more influential than her partner in her decision to breastfeed. Also a woman's mother was a significant determinant on the woman's attitude about breastfeeding. If the woman's mother had a positive attitude about breastfeeding or breastfed herself the woman was more likely to breastfeed ($p < .01$) than those women who had mothers that did not breastfeed ($N = 64$). Alexy and Martin (1994) found that the mother's family was the strongest influence for her not choosing breastfeeding. Positive encouragement from her mother was significant at the $p < .001$ level.

Specific cultural populations have been studied to determine what influenced their infant feeding choices. Hannon, Willis, Bishop-Townsend, Martinez, and Scrimshaw et al. (2000) determined that the Latino and African American populations of women were more affected by perception and social influence than non minority women.

Higginbottom (2000) studied women who were of direct African descent that were now living in England and found that they were influenced by the new social context when deciding on infant feeding method. These studies suggest that social influence is a strong factor in deciding infant feeding method.

The Theory of Planned Behavior has been studied as a theoretical explanation of breastfeeding intention. The TPB, which proposes that behavior is determined by intention and ability, was applied to a breastfeeding study to explain intention by Wambach (1997). A causal model was used to predict breastfeeding behavior by intention ($N = 135$). In the first step of the analysis the effects of attitude, subjective norm and perceived behavioral control were correlated with breastfeeding intentions. Attitudes and perceived control were significant ($F = 21, p = < .001$). A second analysis tested these factors to breastfeeding duration ($F = 6.7, p = < .01$) and only breastfeeding intention had an effect. The results showed attitude and perceived behavioral control predicted breastfeeding intentions ($p < .001$). Subjective norms, defined as people influencing the women's decision to breast feed, were not found to be predictors of intention to breastfeed. Explanations may be theoretically derived from Ajzen's (1998) work which suggests that some intentions by virtue of their nature weigh more heavily on attitude than subjective norms. The results from this study did not support the results of Manstead et al. (1983) that found positive correlations between social norms and breastfeeding intention.

Summary of Breastfeeding Literature

The review of breast feeding literature reveals many integrated and well designed

studies which have the purpose of identifying why more women do not breastfeed when immunological studies show gained benefits for both mother and infant. These studies have analyzed the decision through behavioral theories, change theories and social theories with no one predictive variable identifiable. Many studies take into consideration demographic variables as well as personal and social influences. Environmental influences, which directly include nursing care has received less investigation and may be an important neglected factor and encompass reflection which may also be needed for the woman to arrive at a decision.

Bottle Feeding Literature

The few articles that advocate bottle feeding as the method of choice present it from a decisional perspective. Norton (1998) discussed the concept of health promotion in relation to infant feeding method. She discussed health as one value that needs to be considered in the infant feeding decision with consideration of family income, partner involvement, and convenience in sharing the care of the baby. She concluded that bottle feeding as a choice is reasonable in countries that have adequate sterilization and cautions health professionals to recognize that decisions are not made “in a social or cultural vacuum” (Norton, 1998, p. 1273).

Gigliotti (1995) wrote a landmark article using three case studies qualitatively to describe feelings in women who chose not to breastfeed and relate their experiences. All three cases involve educated clients who relate feeling of guilt imposed on them by health professionals because they did not choose to breastfeed. Gigliotti encouraged reexamining values related to woman decision-making about infant feeding method and

to respect the personal nature of the feeding decision. The Gigliotti study was met with many rebuttals including a commentary by Walker (1996) who contended that the feelings of guilt perceived by the clients in Gigliotti's case study were internally derived and that choosing not to breastfeed was "politically incorrect" (1996, p. 64). In 1998, Gigliotti related the controversial issues of infant feeding choice to a singular case study by discussing the conflict as a nursing diagnosis: decisional conflict. Decisional conflict was discussed within the Neuman Systems Model using a holistic approach. The woman with the nursing diagnosis of decisional conflict demonstrated traits including uncertainty, delayed decision-making and vacillation.

Jones (1998) wrote a commentary supporting freedom to choose an infant feeding method. She stated that each mother and baby deserves to be viewed as an individual unit and concluded "what is best for the mother will inevitably be best for her child" (Jones, p. 1094).

Bennison (1997) related her own experience through an anecdotal case analysis of how breast feeding did not work for her. Her discussion focused on the unnecessary guilt placed on mothers that bottle feed by others in society.

Summary of Bottle Feeding Literature

The scant literature on bottle feeding emphasizes the importance of personal choice in the decision-making process. It upholds the values of individuality and self determination as primary in a social system that advocates a specific alternative for documented medical benefits.

Infant Feeding Method Summary

The literature presented discusses why women choose or do not choose an infant feeding method from many different aspects and theories. Most research includes major groupings of variables such as demographics, professional and non professional influences, self-concept issues and lifestyle alterations. The most abundant studies compare demographic issues such as age, parity and socioeconomic income. Many studies are specific to minorities and women of low socioeconomic income status because their breastfeeding rates are proportionately lower than the general obstetrical populations studied in the United States, Canada, Britain and Australia (Alexy & Martin, 1994; Coombs, et al., 1998; Dodgson & Struthers, 2003; Hannon et al., 2000; Hawkins & Heard, 2001; Higginbottom, 2000; Hill, 1988; Martens, 2001; McIntyre et al., 2001; Meyerink & Marquis, 2002; Milligan et al., 2000; Raisler, 2000; Underwood et al., 1997; Williams & Pan, 1994).

These studies, suggesting numerous variables as being influential in choosing a feeding method, were previously summarized in Table 1. Demographic variables depict a breast feeder to be white, middle class, married, and have a better education (Giugliani et al., 1994). Factors that influence feeding choice come from both within the women, intrinsically, such as wanting control over their lives and from external factors in her environment such as spousal preference (Wells et al., 2002). All variables should be considered when counseling mothers in choosing infant feeding methods.

Chapter Summary

Emancipated decision-making in women's healthcare is a relatively

unexplored concept. Decisional science has grown tremendously within the past two decades due to the work of the Ottawa Decisional Support Framework and the studies it has generated. The framework confirms that decisional aids assist the patient to evaluate many of the variables involved in a decision. Some of these variables include how much conflict a decision produces, the consequences of the alternatives, the values placed on each alternative and the social system in which the decision is made. These studies have revealed the multi-faceted issues of decision-making for all patients and have recognized social influences as an important factor.

The infant feeding studies are vast and many variables have been investigated in relation to the infant feeding decision a woman makes. The variables can be categorized into intrinsic, originating within the woman herself, or extrinsic, related to reasons external to the woman. Variables related to the infant feeding method have also been related to behavioral and social theories. These theories provide insight into the components of human behavior that foster motivation and change. None of the breast feeding studies fully explains the phenomena of why women in the United States do not reach the goals of breast feeding set by Healthy People 2010.

All the studies about decision-making, gender specific and non gender specific recognize social factors as an important and influential aspect. The Wittmann-Price Theory of EDM views the social aspect as a possible negative influence which is assuming that it can be oppressive. This is substantiated by the history of oppression of women in society, the history of the patriarchal health education and research systems, healthcare literature and the clinical observation of the researcher.

There is support within the studies for the subconcepts identified in the Wittmann-Price Theory of EDM. The active role of the patient in the decision-making process is becoming clearer in today's healthcare system. The current view of the patient is changing and they are considered partners with the professional healthcare provider in rational decision-making about their health care-issues (Pierce & Hicks, 2001). Healthcare providers are recognizing that patients are their own experts because only they can evaluate their own experiences, social circumstances, values, attitudes and preferences (Coulter, 2001).

The literature retrieved using emancipation and decision-making as keywords is rudimentary. The breastfeeding literature and studies are abundant thereby rendering it a viable decision-making exemplar with known variables for application to the subconcepts in the Wittmann-Price Theory of EDM. Many studies have explored the decisions women make in choosing treatments or lifestyle options in healthcare. These studies reveal some common threads. Information gathering from non professional as well as professional sources and consultation with family and friends are strong indicators in decision-making, exemplifying the role of social norms as an important subconcept. Personal knowledge is also recognized within the context of experience, values and attitudes as important aspects in women's decision-making (Allen, 1985; Berragan, 1998; Freire, 1970). Providing the time and mode to exchange ideas about the decision or to think about the alternatives is also a trend in the literature. This time and space aspect needed for decisions can be conceived as reflection and flexibility (August-Brady, 2000).

Understanding decision-making in relation to women's health should be a nursing

care priority due to the fact they make up 50% of the population and have specific health needs related largely to their actual or potential childbearing abilities which contributes to the survival of the next generation (Button, 1999). In an informational article written by Mitchell (2000), Dr. Griggs, of the University of Rochester Cancer Center in New York is quoted, in reference to the decisional dilemma of lumpectomy versus mastectomy. Griggs stated that “a woman’s decision is deeply personal, it’s her breast and her body and she has to live with the consequences” (Mitchell, p. 21). Decision-making for all women’s healthcare issues can be considered personal because of their effect on life and lifestyle, yet balancing personal knowledge and professional information in the decisional process is still poorly understood.

CHAPTER 3

METHODOLOGY

The primary purpose of this study was to test the subconcepts of emancipated decision-making in women's healthcare, using women's choice of infant feeding method as the clinical exemplar. The secondary purpose was to explore the relationship of emancipated decision-making and satisfaction with the decision. Emancipated decision-making in women's healthcare is a theoretical concept grounded in history, explained by Critical Social, Feminist, and Freire's Emancipatory Education theories and described through an extensive review of the literature and observed in this researcher's clinical practice. This study served to test and refine subconcepts in the ongoing theoretical development of the Wittmann-Price Theory of Emancipated Decision-making (EDM). This chapter discusses the methodology used in this study, including the research design, description of the sample, setting, institutional review processes, data collection procedure, and the procedures to protect subjects. The discussion of instrumentation will include a description of the three tools that were used; Subject Demographic Questionnaire (SDQ), the Wittmann-Price EDMS, and the Satisfaction with Decision (SWD). The data collection procedure used is fully outlined as well as the statistical analyses of the collected data.

Research Design

This study used a descriptive correlational design to test the subconcepts of emancipated decision-making in women's healthcare, using women's choice of infant feeding method as the clinical exemplar. This study also explored the relationship of an

emancipated decision-making process and satisfaction with the decision. The five identified subscales of an emancipated decision-making process were empowerment, flexible environment, personal knowledge, reflection and social norms. The data set was analyzed in order to identify the significance of each factor in relation to an emancipated decision-making process. The research design was retrospective, without random sampling of subjects due to self-selection of hospitalized subjects (Burns & Grove, 2005).

Threats to Validity

The study was designed to protect the data from threats to construct validity. The first possible threat, inadequate preoperational explication of constructs, was protected by three measures. The first measure was the completion of an extensive literature review with explanation and synthesis of all five subconcepts (Wittmann-Price, 2004). Secondly, clear linkages were made between the conceptual and operational definitions of the subconcepts, and lastly, expert validation of the subconcepts was obtained. The method and results of expert validation are described later in this chapter.

Preliminary Instrument Tested for Content Validity

The internal validity threat of selection was controlled for by administering the instruments to subjects at least 18 years of age. Interactions with selection were also controlled for by administering the instruments to subjects when the researcher was not the nurse assigned to provide care for those patients. The researcher was not scheduled to work as part of the professional staff of the collection site, postpartum unit, during the data collection time period. Instrumentation deficits were controlled for by obtaining an

adequate sample size as determined by statistical analysis for power and effect, and is explained in further detail later in this chapter. Evaluation apprehension was controlled for by providing written and verbal explanation to the subjects that their nursing care would not be affected in any way by their choice of whether or not to participate in the study (Burns & Grove, 2005).

The study design was protected from external threats of validity of interaction of selection and treatment since the researcher was not participating in the direct care of the subjects. Rigorous standards of data collection included supplying an easily sealable (self adhesive) envelope with the researcher's name for completed research questionnaires. Other environmental controls were included such as locating the collection box for the envelopes in an accessible, secure place to prevent tampering with the research questionnaire. Also the investigator distributed the research questionnaires to subjects every other day and collected completed research questionnaires every other day to reduce the time research questionnaires were left unattended on the nursing unit. Once the research questionnaires were collected they were stored in a locked file in the researcher's office.

Sample Selection and Setting

Characteristics of Sample

The target population for this investigation was subjects who delivered uncompromised term infants, and who had decided on and enacted an infant feeding method within the first day of birth. The accessible population, or the portion of the target population that was accessible to the researcher, was hospitalized subjects in a local

institution. The sample was a non-probability, convenience sample for exploratory purposes (Burns & Grove, 2005).

The subjects for this investigation were from one hospital within the Lehigh Valley of Pennsylvania. This location was chosen due to accessibility for the investigator and familiarity with the hospital units.

Sampling Criteria

Subjects were included in this study based on the following criteria:

They were at least 18 years of age or older.

They had delivered an uncompromised newborn admitted to the newborn nursery.

They had initiated feeding within the first day postpartum.

They had reported being comfortable reading and writing English.

They had no history of breast surgery which precluded breastfeeding.

Description of the Study Sample

The age of the sample ($n = 96$) ranged from 18 to 50 ($M = 29.74$, $SD = 5.78$). Of the subjects surveyed who had other children ($n = 57$), parity ranged from 1 to 5 with 36% of total subjects having one other child and 25% having two or more children ($M = 1.1$, $SD = 1.12$). The sample was mostly white (78%) and the majority (88%) lived with the infant's father. The subjects were well-educated, with more than 80% indicating that they had at least some college education. Five of the surveyed subjects had breast surgery but none of the surgeries precluded breastfeeding. Two subjects surveyed stated that they did not begin to breastfeed their baby within 24 hours but explained the reason in the space available on the form that they both had contact with their babies but were having a

difficult time getting the baby to latch on to the breast. Frequency statistics of demographic variables are presented in Table 3.

Sample Size

The required minimum sample size was determined by power analysis. Power is the probability of rejecting the null hypothesis when it is false and is based on the interrelationship of four parameters: sample size, significance level, effect size and power. Power is the capacity of the investigator to detect satisfaction using each of the five predictor variables: empowerment, flexible environment, personal knowledge, reflection and social norms. The power analysis was completed based on the formula developed by Cohen (1988) to determine minimum sample size. For a moderate effect size of .13 to reach a power of .80 with five predictor variables in a multiple regression analysis with an alpha of .05 based on sample power program, the minimum required sample size was 92 subjects (Munro, 2005). The actual sample size was 97.

Setting

The subjects for this study were recruited from a Lehigh Valley, PA hospital which services clients primarily from Northampton and Lehigh Counties. The most current birth rate statistic for these combined counties was 7,002 live births for the year 2003 (PA Department of Health, 2004). The hospitals in the Lehigh Valley include two urban hospitals and two suburban hospitals. The hospital used in this study was in a suburban setting. A one-month data collection period had the potential of producing 200 subjects with an estimated 9.3% to 12.3% exclusion rate for premature infants and a 9% exclusion rate for relationships that may exist in the population. Sample size was

computed based on a power of .80, since 80% is generally viewed as a level adequate to

Table 3.

Frequencies of Demographic Variables.

Variable	Categories	<u>n</u>	%
Ethnicity (<u>N</u> = 97)	White	76	78.40
	African American/Black	3	3.10
	Hispanic/Latino	14	14.40
	Asian/Pacific Islander	3	3.10
	Other	1	1.00
Language spoken (<u>n</u> = 96)	English	91	94.80
	Spanish	4	4.20
	Other	1	1.00
Education level (<u>n</u> = 96)	Some High school	6	6.30
	Completed High School	12	12.50
	Some College	27	28.10
	Completed College	28	29.20
	Some Graduate school	8	8.30
	Completed Graduate School	15	15.60
Living arrangements (<u>n</u> = 95)	Alone	6	6.30
	With the father of the baby	84	88.40
	With Relatives	4	4.20
	Other arrangements	1	1.10
Work while pregnant (<u>n</u> = 96)	No	39	40.60
	Yes	57	59.40
Returning to work (<u>n</u> = 94)	No	31	33.00
	Yes	63	67.00
Yearly household income level (<u>n</u> = 91)	Below \$15,000	8	8.80
	\$15,000 to \$30,000	17	18.70
	\$31,000 to \$45,000	10	11.00
	\$46,000 to \$60,000	14	15.40
	\$61,000 to \$75,000	14	15.40
	Above \$75,000	28	30.80

(table continues)

Variable	Categories	<u>n</u>	%
Breast surgery (<u>n</u> = 95)	No	90	94.70
	Yes	5	5.30
Feeding method used for other children (<u>n</u> = 57)	Breast only	11	19.30
	Bottle only	22	38.60
	Breast & bottle	24	42.10
Able to feed new baby within 24 hours (<u>n</u> = 96)	Yes	94	97.90
	No	2	2.10
Feeding method chosen for this infant (<u>n</u> = 95)	Breast only	47	49.50
	Bottle only	28	29.50
	Breast and bottle	20	21.10
Plan for feeding method at home (<u>n</u> = 95)	Breast only	38	40.00
	Bottle only	27	28.40
	Breast and bottle	30	31.60
Feeding method used for other children (<u>n</u> = 57)	Breast only	11	19.30
	Bottle only	22	38.60
	Breast & bottle	24	42.10

reject the null hypothesis and avoid a Type II error in statistical analysis (Munro, 2005).

The moderate effect size of .13 reflects the degree to which the phenomenon, the emancipated decision-making process, is present in the population. A .05 level of significance (two-tailed) was used because the hypotheses were non-directional. This level of significance determined if the sample tested was representative of the population being studied (Munro).

A multiple regression analysis was computed on the criterion variable of adult subjects, yielding approximately 160 possible subjects. At an anticipated 25% return research questionnaire rate (Treece & Treece, 1977), the sample estimate was 120

subjects for a three-month collection period. The actual data collection period was just under seven weeks during the summer of 2005.

Instrumentation

Data collection consisted of the combination of three instruments: the SDQ, the EDMS and the SWD.

Subject Demographic Questionnaire(SDQ)

Development

The first instrument used in this study was a SDQ (Appendix A) developed by the researcher to describe the sample. First, the SDQ asked age to eliminate teenage subjects under the age of 18, although, legally, they are considered emancipated minors, they may have developmental issues which interfere in independent decision-making (Martins, 2001). Secondly, the SDQ elicited subjects' race since the literature described cultural influences on feeding choices (Underwood et al., 1997). The questionnaire also asked subjects' primary language and if they were comfortable reading and writing English (questions 3 and 4) in order to ensure understanding of information being sought and avoid complications with implied consent.

The next five questions (5 to 9) of the SDQ were attributes extracted from the literature review about breastfeeding. Some studies found that women who chose to breastfeed were older, married, better educated, and economically more secure than women who bottle feed (Mathews et al., 1998). Other studies about infant feeding method choice indicated parity and experience as significant factors (Barber et al., 1997; Kieffer et al., 1997; Meyerink & Marquis, 2002; Milligan et al., 2000), therefore,

questions 11 and 12 asked for this specific information. Questions 7 and 8 requested information about women's intent to return to work, which is an issue often cited by women for choosing bottle feeding as their alternative (Matthews et al., 1998; Norton, 1998). Questions 10 and 13 were included to determine if there were any medical complications that would inhibit women from making a free choice of feeding methods. Questions 14 and 15 asked about actual method of feeding intention and initiation.

The Wittmann-Price Emancipated Decision-making Scale (EDMS)

Development

The EDMS was constructed by the researcher once the subconcepts were identified and defined (Wittmann-Price, 2004). Statements which reflected each of the subconcepts were developed and a 5-point Likert scale was used to describe the intensity of the statement. Originally, 50 statements were drafted about Emancipated Decision-making, using the clinical exemplar, choice of infant feeding method. The final version of the EDMS had 35 items. The Flesh-Kincaid Grade Level, on the final EDMS was calculated to be a 6.9 grade reading level and formatting was consistent with the SWD scale for ease in reading and rating.

Validity

The instrument, developed by the researcher to explore the five subscales of emancipated decision-making, was based on extensive literature review and the researcher's clinical observation and was judged by five experts to establish the content validity. The five experts included all doctorally prepared nurses. Three had expertise in decisional science and two had expertise in maternal-child healthcare. Experts were

asked, independently, to evaluate each item on the instrument based on two criteria; relevancy for inclusion in the instrument and match to a theoretical subscale. The intent of the study was explained in an introductory letter (Appendix B). The subscales were defined on the original draft of the instrument (Appendix C).

Once the results from the experts were received, item analysis was calculated. All 50 items were retained on the EDMS for pilot testing because all 50 items had 60% agreement or higher on relevancy and 49 out of 50 items had 60% or higher agreement on subscale representation. One item (# 37) did not have at least 60% consensus on its subscale but was included in the pilot study for consistency in numbering. It was not included in the final version of the instrument.

Reliability

Pilot study version of EDMS.

A pilot study was concluded to gather estimated reliability data for the EDMS. A reliability coefficient of .80 is acceptable (Burns & Grove, 2005). Ten items were recoded to reflect positive answers. When analyzed for reliability with 49 items the reliability on the instrument was .78.

Items with negative item-to-item correlations were then removed to arrive at a 40 item version of the EDMS with an alpha of .87. The alpha of the five subscales ranged from .59 to .81. Reliability of the five subscales was then analyzed for contribution to the total instrument. Total EDMS and subscale reliabilities for the pilot and full study are summarized in Table 4.

Final version of EDMS.

For the total EDMS, consisting of 35 items, Cronbach's alpha for internal consistency was .88. A reliability coefficient of .70 is adequate for a newly developed instrument (Munro, 2005). The final instrument (Appendix H) was constructed by randomly ordering and renumbering the 35 items. The alphas for the five subscales ranged from .48 to .88 for the final version of the EDMS, details in Table 4.

Table 4.

Reliability of Emancipated Decision-making Process Totals and Subscales Scores.

Subscale	Number of items	Items retained on the EDMS final version	Pilot study alpha	Full study alpha
TOTAL	35		.88	.88
Empowerment	3	1, 2, 33	.59	.56
Flexible Environment	4	16, 18, 21, 22	.81	.59
Personal Knowledge	12	5, 8, 10, 14, 17, 19, 24, 28, 30, 32, 34, 35	.81	.88
Reflection	5	9, 11, 20, 24, 29	.71	.48
Social Norms	11	3, 4, 6, 7, 12, 13, 15, 23, 25, 26, 31	.75	.72

Scoring

The EDMS was scored as a unidimensional scale and a summed total score was used for all analyses. Scoring of the EDMS was based on a 5-point Likert scale. Seven questions (items 4, 7, 13, 15, 23, 25, and 29) were reverse coded because they reflected negative statements. Each subject's responses to the 35-items were summed to yield a total score. Subscale scores were calculated by summing each subject's response to the items within each subscale. The possible range of total scores was 35 to 175 for an emancipated decision-making process. The possible range within each subscale is presented in Chapter 4, Table 6.

Satisfaction with Decision Scale (SWD)

Description

The instrument used to test the women's satisfaction with her decision is the Satisfaction with Decision Instrument (SWD) (Appendix I). The SWD was developed by Holmes-Rovner et al. (1996). It measures three aspects of a decision which are attributes of an effective decision. These attributes relate to the decision and inquire if the decision was informed, if the decision was consistent with the person's values and if the decision was carried through. These attributes are credited to O'Connor's research on decision-making (Holmes-Rovner et al., 1996). Permission to use the SWD scale was obtained through email from Dr. Margaret Holmes-Rovner (Appendix J). In return for its uncompensated usage, the author requested a copy of the dissertation abstract and statistical results.

The SWD scale was originally developed to evaluate the decisional support of

women taking hormone replacement therapy. It was devised after a literature review revealed inadequate tools for measuring a woman's satisfaction with a healthcare decision independent of provider satisfaction, the amount of decisional conflict, and the extent of decisional certainty about an intervention. The authors' goals in developing the SWD scale were to measure the woman's overall satisfaction with the decision and to differentiate the satisfaction with the decision from other issues of satisfaction such as satisfaction with the provider, resolution of decisional-conflict and intervention. The development of the SWD scale was to devise a tool that was short, easy to use, and reliable. The SWD scale consists of 6 items based on a 5-point Likert scale. The responses range from 1 - strongly disagree to 5 - strongly agree (Holmes-Rovner et al., 1996).

Construct Validity

Construct validity was validated by Holmes-Rovner et al. (1996) by piloting the SWD scale along with four other decision-making scales, the Decisional Conflict Scale (DC) (O'Connor, 1994), the Decisional Confidence Scale designed by Estes and Hosseini (1988), the Satisfaction with Provider scale devised by Linder-Pelz and Struening (1985), and the Health Status Restriction (HSR) scale which measured knowledge about HRT. Holmes-Rovner et al. theoretically predicted a negative correlation between the Decisional Conflict Scale and the SWD scale, a positive correlation with the Decisional Confidence scale. The SWD scale was analyzed for discriminate validity by comparing it with the DC scale and the HSR scale because they were conceptually similar. A principal-components analysis was done on items on all three scales to determine if the

SWD scale was unique in measuring the satisfaction with the decision as opposed to satisfaction with the prognosis. The factors analysis by varimax rotation discriminated SWD scale items when they did not load on the same items of other two scales (Holmes-Rovner et al.).

Wills and Holmes-Rovner (2003) assessed construct validity of the SWD scale with depressed primary care patients ($N = 97$) who had decided to use antidepressants. The wording of the scale was adapted to reflect the content of antidepressants. It was used along with the Decision Conflict scale (DC) which is a 16-item scale that assesses level of decisional conflict with a healthcare decision and the Centre for Epidemiological Studies Depression scale that was used for evaluation of the depression, the Physician Participatory Decision-making style scale which measures the patients perception of shared decision-making, and a knowledge scale about depression. Scores on the SWD scale correlated modestly with the Decisional Conflict scale (.66) and evaluation of depression (.35), and correlated weakly to education (.22), satisfaction with provider (.23), and knowledge of the health issue (.21). It did not correlate with income. This correlational matrix supported the SWD scale as a unique and independent measure of satisfaction with decision-making.

Reliability

Reported internal consistency results for the SWD have been above .80. Holmes-Rovner et al. (1996) reported a Cronbach alpha internal consistency reliability of .86. Wills and Holmes-Rovner (2003) report an internal consistency reliability of $\alpha = .85$. O'Connor (1994) used the SWD scale in a study of elderly women ($N = 238$) regarding

immunization for influenza. The study used three groups of subjects to test the SWD scale and resulted in $\alpha = .84$, which is acceptable for a psychometric instrument (Burns & Grove, 2005). In the current study, Cronbach alpha reliability for the SWD scale was .89 ($N = 95$).

Scoring

The SWD was scored as a unidimensional scale and a summed score was used for analysis. Scoring of the SWD scale was based on a 5-point Likert scale which determined the options or attitude of the subject to a number of declarative statements. Subjects' responses to the 6-items were summed to yield a total score. The possible range of scores was 6 to 30. A higher score reflects higher levels of satisfaction.

Pilot Study

Protection of Rights Subjects in Pilot Study

The Institutional Review Board of Widener University reviewed and approved the pilot study for solicitation of subjects in July of 2004 (Appendix E) and permission from the hospital Research Evaluation Committee was granted in August of 2004 (Appendix F).

Conducting the Pilot Study

The pilot study was conducted over a seven day period in August, 2004. The reasons for pilot testing the instrument were to estimate the reliability of the instrument and to refine the data collection method (Burns & Grove, 2005). An acceptable number of subjects for the pilot study ($N = 10$) was calculated at 10% of the total of subjects of the full study (Treece & Treece, 1977). To ensure reliable results about the pilot

instrument a total of 15 completed research questionnaires was the projected goal.

The researcher distributed the letter of intent (Appendix G) along with the research questionnaire, including both the SDQ and the EDMS. This procedure was done on a daily basis for one week and yielded a 50% return rate. Nineteen pilot study research questionnaires were returned from 40 distributed research questionnaires. Only 18 research questionnaires were included in the study because 1 questionnaire was incomplete. The 36% return rate was greater than the projected 25% return (Treece & Treece, 1977).

Pilot Study Data Analysis

The demographic data collected were analyzed for frequency distributions to provide an overall picture of the sample. SPSS Version 13.0 was used for all data analyses. The mean age was 28.76 years ($SD = 5.23$), with ages ranging from 20 to 40 years. None of the subjects reported previous breast surgery. All of the subjects described their primary language as English and indicated they were comfortable reading English. Detailed frequencies of the demographic data are presented in Table 5.

The original question 13 on the pilot study asked subjects if they were able to feed their baby within the first four hours of birth. The question was originally designed to exclude infants who may have been admitted to the neonatal intensive care unit and/or subjects admitted to a critical care unit. Three subjects indicated they were unable to feed within four hours of birth due to having a Cesarean delivery and being retained in Post Anesthesia Recovery Unit. Since Cesarean deliveries are not indicated as a feeding deterrent in the literature review, Question 13 was revised to ask if the subject was able to

feed within the first day of the infant's life.

Table 5.

Description of subjects ($N = 18$).

Variable	Category	n	%
Race	White	16	88.90
	White and Hispanic	2	11.1
Education level	Completed High School	4	22.20
	Some College	4	22.20
	Some College College		
	College Degree	8	44.40
	Some Graduate School	1	5.60
	Graduate Degree	1	5.60
Living arrangements	Lives with the baby's father	17	99.40
	Lives with friends	1	5.60
Work before birth of baby	No	4	22.20
	Yes	14	77.80
Plan to return to work	No	2	11.10
	Yes	16	88.90
Household yearly income level	\$15,000 to \$30,000	4	22.20
	\$31,000 to \$45,999	1	5.60
	\$46,000 to \$60,000	4	22.20
	\$61,000 to \$75,000	6	33.30
	Above \$75,000	3	16.70

(table continues)

Variable	Category	n	%
Other children	1 other child	6	46.20
	2 other children	6	46.20
	11 other children	1	7.60
Feeding method for other children	Breast fed only	1	5.60
	Bottle fed only	5	27.80
	Breast and bottle fed	7	38.90
Able to feed new baby after birth	Yes	10	55.60
	No	8	44.40
Other children	1 other child	6	46.20
	2 other children	6	46.20
Feeding new baby	Breastfeeding only	8	44.40
	Bottle feeding only	6	33.30
	Breast & bottle feeding	4	22.20
Feeding plan for home	Breastfeeding only	4	22.20
	Bottle feeding only	7	38.90
	Breast & bottle feeding	7	38.90

In the pilot study, the profile of a sample subject was that of a 29 year old White woman with a college education with a family income level of \$61,000 to \$75,000. The typical subject worked and had other children at home. The children at home were typically combination (breast and bottle) fed as infants. The typical subject was currently breastfeeding her new baby while in the hospital but planned to switch to bottle or combination feeding at home.

Protection of Human Rights Final Study

The study was begun after written approval was obtained from the Widener University Institutional Review Board in June of 2005 (Appendix K), following review for Protection of the Rights of Subjects. Written approval was received from the Institutional Research Evaluation Team of the data collection site also in June of 2005 (Appendix L). Data collection began on June 19, 2005 and concluded on August 2, 2005 after the collection of 98 research questionnaires. This research study was not funded by any outside sources.

Privacy and Confidentiality

All subjects were adults (18 years of age or over) and voluntarily consented to participate in this study by implied consent. Subjects were assured by the researcher and in the Letter of Explanation (Appendix M) that their decision whether or not to participate would not influence the quality of care they or their infant received while in the hospital. In addition, subjects had the right to discontinue or withdraw from the study at any time for any reason.

Subjects did not put their names on the research questionnaires; therefore, all research data were anonymous. All data were analyzed and reported as group data only as stated in the Letter of Explanation.

Since the postpartum unit functioned under the philosophy of family-centered care, visiting hours were not restricted. There was no control of who was in the private postpartum room with the women when she filled out the survey.

Risks

While no harm to subjects was expected, there was a slight possibility that subjects may have experienced some emotional distress while completing the research questionnaire. This may have been the case if the infant feeding decision was a difficult one or one that has produced a conflict with another person in the subject's life. Subjects were informed in the Letter of Explanation and by the researcher that if they experienced distress they could withdraw from the study and return the incomplete research questionnaire by placing it in the box provided. All subjects returned completed surveys, indicating there was no evidence of subject withdrawal or distress in this study.

Benefits

The study's intent was to add to nursing's knowledge about women's decision-making, therefore there were no direct benefits to subjects in this study. Subjects did not receive any remuneration for participation in this study.

Storage of Data

All completed research questionnaires were stored in the researcher's office in a locked cabinet. The research questionnaires will be destroyed after completion of the study.

Implied Consent

Completing and returning the questionnaire anonymously was considered implied consent for all subjects. After obtaining a list of women who met the study's inclusion criteria from the primary staff nurse, the researcher introduced herself to the potential subject and provided a brief explanation of the study. All subjects were informed of the

time commitment of approximately 20 minutes needed to complete the research questionnaire. Subjects were reminded of their right to withdraw from the study for any reason and discontinue completion of the research questionnaire at any time.

Data Collection Procedure

This researcher obtained the name of eligible subjects from the primary nurse every other day. The researcher introduced herself and purpose to the subject and distributed a Letter of Explanation and the research questionnaires along with a self-sealing envelope. The Letter of Explanation had a Flesh-Kincaid grade level of 8.1. A short explanation and intent of the study was provided verbally to the subjects as previously described. The subjects sealed the completed questionnaire in the provided envelope and placed it in a labeled box located on the stationary chart rack that was next to the nurses' station located in the center of the postpartum unit labeled "Completed Nursing Research Questionnaires for Ruth Wittmann-Price".

The researcher emptied the box of questionnaires every other day while the study was in progress. Distribution of research questionnaires was also done every other day until the desired number of completed research questionnaires was obtained.

Data Analyses

Introduction

The data were entered into an electronic file and analyzed using SPSS version 13.0 on a personal computer in the researcher's office.

Missing data

Missing data on the SDQ were left blank. The mean scores of the sample were

calculated for all 35 statements on the EDMS and for the 6 statements of the SWD scale and used to replace missing data on the instruments. Thirteen subjects had one to four responses missing on the EDMS. Since the missing items were less than 10% of the subject's data they were replaced with the item mean calculated from the responses of the remaining subjects. Two subjects skipped one item each on the SWD scale and these two missing data points were replaced with the group mean for the item.

Descriptive Statistics

Descriptive statistics were computed for the SDQ. Mean age was computed. Frequency for items 2 to 15 was reported in tabular form. Descriptive characteristics of the subjects are summarized in narrative form and presented in detail in Table 5.

Research Question Testing

Research Questions 1 and 2 were posed to address the primary purpose of this study and were as follows:

1. What are women's scores on total emancipated decision-making and the five subconcepts of emancipated decision-making?
2. What are the relationships among the five subconcepts of emancipated decision-making and the total emancipated decision-making scores?

The research questions were answered through descriptive statistics. Measures of central tendency and dispersion, as well as Pearson correlations, were computed.

Hypotheses Testing

Research Questions 3 and 4 were investigated through the testing of the following

research hypotheses. Research Questions 3 and 4 are:

3. What is the relationship between emancipated decision-making and satisfaction with the decision about infant feeding method in women?
4. Does the combination of the subscales of emancipated decision-making (empowerment, flexible environment, personal knowledge, reflection and social norms) predict satisfaction with the decision about infant feeding method in women better than any one element alone?

Hypothesis 1: Emancipated decision-making is directly related to satisfaction with the decision about infant feeding method. This hypothesis was answered by the Pearson product-moment correlation coefficient and the variables were expected to be linearly related.

Hypothesis 2: The linear combination of the subscales of emancipated decision-making (empowerment, flexible environment, personal knowledge, reflection and social norms) predict satisfaction with decision-making better than any one element alone. This hypothesis was addressed using a stepwise multiple regression analysis. Multiple regression analysis was appropriate because the study was interested, not only with the correlation between the two major variables an emancipated decision-making process and satisfaction with the decision-making, but also with the significance of the overall R and the significance of each subscale or predictor variable to the dependent variable (Munro, 2005). Forward stepwise regression analysis of the data was computed to reveal the change on R after each variable was entered. This analysis shows the statistical significance of each variable entered and provides information about the significance of

each subscale (Burns & Grove, 2005).

Additional Analyses

Age, parity, intention to feed, method of feeding other children, income and education were explored in relation to EDMS and SWD scale using correlations, t-tests, and analysis of variance statistics, as appropriate for the level of measurement of each of the variables (Burns & Grove, 2005).

Chapter Summary

Chapter 3 discussed the methodology used to collect the data to test the concept of emancipated decision-making. Three data collection instruments were administered to subjects that meet the inclusion criteria in the postpartum hospitalization period. The sample was representative of the target population of postpartum women in the Lehigh Valley and was obtained through convenience using a non probability method. All necessary steps to protect the rights of the subjects and to maintain anonymity and confidentiality were taken. The demographic data were calculated using frequency statistics and the Wittmann-Price EDMS was analyzed by forward stepwise regression analysis.

The Satisfaction with Decision (SWD) scale was analyzed by multiple regression analysis. All analyses were computed using a SPSS version 13.0 on a personal computer. Additional analyses were done to explore demographic variables with emancipated decision-making to identify any trends.

CHAPTER 4

DATA ANALYSIS

The primary purpose of this study was to test the subconcepts of the emancipated decision-making in women's healthcare, using women's choice of infant feeding method as the clinical exemplar. The secondary purpose was to explore the relationship of an emancipated decision-making process and satisfaction with the decision. Emancipated decision-making in women's healthcare is a theoretical concept grounded in history, explained by Critical Social, Feminist, and Freire's Emancipatory Education theories and described through an extensive review of the literature and this researcher's clinical practice. This exploration served to test and refine subconcepts in the ongoing theoretical development of the Wittmann-Price Theory of EDM.

This chapter describes the findings of the data collected by the process outlined in Chapter 3. Data were collected for a six week period from June to August, 2005. Two-hundred and thirty five surveys were distributed with a return rate of 40%. Ninety-eight surveys were obtained and the raw data were entered into a personal computer using SPSS version 13.0.

Data Management

Data were entered into SPSS version 13.0 on a personal computer. After all 98 data from the research questionnaires were entered; the data were prepared for analysis. One questionnaire was deleted because the subject left 14 statements blank on the EDMS. Of the 97 remaining subjects, 2 left the last page of the SWD blank but completed the EDMS; therefore, data from these 2 subjects were included in analyses for Research

Question 1.

Research Question 1

Research Question 1 asked, “What are women’s scores on emancipated decision-making and the five subconcepts of emancipated decision-making?” Women’s scores on emancipated decision-making and all five subconcepts were analyzed by descriptive statistics as shown in Table 6.

Table 6.

Descriptive statistics of EDMS total and subscale raw scores ($N = 97$).

	Mean	Standard Deviation	Observed range	Possible range	Possible mid-point
EDMS total	140.71	14.00	86 - 168	35 - 175	105
Empowerment	10.87	2.23	3 - 15	3 - 15	9
Flexible environment	17.21	2.16	10 - 20	4 - 20	12
Personal knowledge	51.16	6.19	38 - 60	12 - 60	36
Reflection	17.49	2.99	10 - 25	5 - 25	15
Social norms	43.63	5.34	25 - 55	11 - 55	33
Satisfaction	26.68	2.77	21 - 30	6 - 30	18

Because subscales varied in the number of items on each of them, subscale mean scores were calculated to allow direct comparison of subscale scores. Descriptive statistics of each subscale mean, in rank order, are presented in Table 7.

Research Question 2

Subjects’ mean scores for each subscale were computed. These

Table 7.

Descriptive statistics of EDMS total and subscale mean scores.

	Mean	Range	<u>SD</u>
Total EDMS	4.02	2.46 - 4.81	.74
Flexible environment	4.30	2.50 - 5	.54
Personal knowledge	4.26	3.17 - 5	.52
Social norm	3.97	2.27 - 5	.60
Empowerment	3.62	1.00 - 5	.49
Reflection	3.50	2.00 - 5	.40

subscale means were used to address Research Question 2 which asked, “What are the relationships among the five subconcepts of emancipated decision-making and total emancipated decision-making scores?”

Pearson correlations of all five EDM subscales and total EDMS were computed. As would be expected for part to whole correlations, all five subscales were significantly correlated with the total EDMS scores. In addition, all subscale intercorrelations were significant except for the relationship between reflection and personal knowledge and between reflection and social norms (Table 8).

Hypothesis 1

Research Question 3 asked, “What is the relationship between emancipated decision-making and satisfaction with the decision about infant feeding method in women? Hypothesis 1 stated that emancipated decision-

Table 8.

Pearsons correlations of 5 EDM subscales and total EDM scores ($N = 97$).

	Total EDMS	Flexible environment	Personal knowledge	Reflection	Social norms
Empowerment	$r = .56$ $p < .001$	$r = .40$ $p < .001$	$r = .24$ $p = .019$	$r = .38$ $p < .001$	$r = .47$ $p < .001$
Flexible environment	$r = .81$ $p < .001$		$r = .67$ $p < .001$	$r = .35$ $p < .001$	$r = .47$ $p < .001$
Personal knowledge	$r = .85$ $p < .001$			$r = .15$ $p = .152$	$r = .62$ $p < .001$
Reflection	$r = .47$ $p < .001$				$r = .15$ $p = .153$
Social norms	$r = .83$ $p < .001$				

making is directly related to satisfaction with the decision about infant feeding method.

Data were analyzed by the Pearson product-moment correlation coefficient, Pearson Correlation of EDMS and SWD scores yielded a significant correlation ($r = .74$, $p < .001$). Therefore, Hypothesis 1 was accepted.

When each of the five subscales was correlated with satisfaction, personal knowledge was the best predictor of satisfaction ($r = .77$), explaining 59.29% of the variance (Table 9). The reflection subscale was not significantly related to SWD ($r = .19$).

Hypothesis 2

Research Question 4 asked, "Does the combination of the subscales of emancipated decision-making (empowerment, flexible environment, personal knowledge, reflection and social norms) predict satisfaction with the decision about

Table 9.

Pearson correlations of EDMS total and subscales scores with SWD ($N = 95$).

	r	p
Total EDMS	.74	< .001
Empowerment	.24	.020
Flexible environment	.63	< .001
Personal knowledge	.77	< .001
Reflection	.19	.073
Social norms	.59	< .001

infant feeding method in women better than any one element alone?" Hypothesis 2 stated that the linear combination of the subconcepts of emancipated decision-making (empowerment, flexible environment, personal knowledge, reflection and social norms) predicted satisfaction with decision-making better than any one element alone.

Hypothesis 2 was analyzed by forward stepwise regression analysis which revealed the statistical significance of each variable entered and provided information about the unique and significant contributions of each subscale (Burns & Grove, 2005). The overall $R = .79$ and personal knowledge was the best predictor of an emancipated decision-making process, explaining 58.67% of the variance ($p < .001$). Flexible environment was also significant ($p = .004$), accounting for 3.5% of the overall R^2 of 62.17%. The subscales of empowerment, reflection and social norms failed to enter the stepwise multiple regression analysis due to high multicollinearity. Reflection, social norms and

empowerment were not significant predictors of satisfaction with the decision. Since the linear combination of personal knowledge and flexible environment predicted satisfaction with decision better than either variable alone, Hypothesis 2 was accepted. The multiple regression results are summarized in Table 10.

Table 10.

Stepwise multiple regression of EDMS subscales on satisfaction with decision-making.

	<u>R</u>	<u>R</u> Square Change	<u>F</u> Change	Sig. <u>F</u> Change
Personal Knowledge	.77	.59	132.11	< .001
Flexible Environment	.79	.04	8.62	.004

Additional Analysis

Additional analyses were computed to explore age, parity, intention to feed, method of feeding other children, income and education in relation to EDMS and the SWD scale. Age and parity were correlated with EDM, SWD and the EDM subscales with two-tailed Pearson Correlation analysis. Subjects' age was inversely related to empowerment ($r = -.34, p = .001$). Age was not significantly correlated with any other variable entered into the analysis. Number of previous children was also inversely related to empowerment ($r = -.29, p = .005$) and reflection ($r = -.31, p = .002$).

EDMS and SWD scores were explored for differences between groups of subjects who did and did not work before the birth and groups who did and did not intend to work after the birth. Independent t-tests were computed and revealed that women who worked

before the birth ($n = 57$, $M = 143.68$) had significantly higher EDMS scores than women who did not work before the birth ($n = 39$, $M = 136.36$) ($t = -2.58$, $df = 94$, $p < .05$). Also, women who intended to work after the birth ($n = 63$, $M = 142.84$) had significantly higher EDMS scores than women who did not intend to work after the birth ($n = 31$, $M = 136.19$) ($t = -2.19$, $df = 92$, $p < .05$). None of the groups differed on SWD scores.

EDMS and SWD scores were computed for ethnicity differences among groups of subjects with no significant difference found using one-way ANOVA. EDMS and SWD scores were also computed to explore differences in educational level, income level, living arrangements and choices of feeding method for past children and no significant differences among groups were found between groups of subjects by one-way ANOVA.

Chapter Summary

The statistical analyses and calculations for the four research questions and two research hypotheses have been presented in this chapter. Both hypotheses posed for this study have been accepted.

Research Question 1 asked, “What are women’s scores on emancipated decision-making and the five subconcepts of emancipated decision-making?” All five subscales had a mean range of 3.5 to 4.3 on scoring system of 5 indicating that the subjects are using an emancipated decision-making process. Research Question 2 asked, “What are the relationships among the five subconcepts of emancipated decision-making and the total emancipated decision-making scores?” The subscales of empowerment and flexible environment were significantly related to emancipated decision-making.

Hypothesis 1 which answered Question 3, “What is the relationship between emancipated

decision-making and satisfaction with the decision about infant feeding method in women? “ revealed a significant correlation. Research Question 4, which addressed the second hypothesis, asked “Does the combination of the subconcepts of emancipated decision-making (empowerment, flexible environment, personal knowledge, reflection and social norms) predict satisfaction with the decision about infant feeding method in women better than any one element alone?” revealed that the combination of personal knowledge and flexible environment explained 62.2% of the variance.

Additional analysis of demographic data found that work history and the intent of the subjects to work after the birth of their infant were the only two demographic variables that revealed differences in subjects’ emancipated decision-making total scores. In addition, age was negatively related to empowerment, and parity was negatively related to empowerment and reflection. Chapter 5 presents discussion on interpretation and significance of the findings.

CHAPTER 5

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

This chapter discusses the results of the study and implications for nursing science, education and clinical practice. Conclusions from the study are summarized and recommendations for use of the findings and future research are made.

The primary purpose of this study was to test the subconcepts of emancipated decision-making in women's healthcare, using women's choice of infant feeding method as the clinical exemplar. The secondary purpose was to explore the relationship of an emancipated decision-making process and satisfaction with the decision.

Discussion of the Results

Sample Characteristics

SDQ data results revealed that the population sampled was primarily, white, well-educated, working, multipara, upper middle-class income level women. The age of the population sampled ($n = 96$) ranged from 18 to 50 ($M = 29.74$, $SD = 5.78$). Of the subjects surveyed who had other children ($n = 57$), parity ranged from 1 to 5 with 36% of total subjects having one other child and 25% having two or more children. The sample was mostly white (78%; $n = 76$) and the majority (88%; $n = 78$) lived with the infant's father. More than 80% ($n = 84$) of the subjects had at least some college education. Five of the surveyed subjects had breast surgery but none of those surgeries precluded breastfeeding. Two of the subjects surveyed stated that they did not begin to feed their infant within 24 hours but provided the reason in a written explanation which stated that they had a difficult time getting their infant to latch on to the breast. Eleven subjects

(19.3%) had previous breast fed and 47 (49.5%) planned to breastfeed this baby and 38 (40%) of those women planned to continue breastfeeding at home.

Comparing the pilot to the full study revealed only one demographic difference which was planning to breastfeed after hospital discharge. The pilot sample ($N = 18$) results revealed that the majority of women planned to combination feed (breastfeed with bottle supplements) at home. This difference in results may be due to the small sample number in the pilot study or the fact that the pilot and the full study were done a year apart and breastfeeding for longer periods of may have become more of a social norm than last year. Increases in sustained breastfeeding may be due to the publicized goals of Healthy People 2010 and the American Academy of Pediatrics (2005) recommendations that human milk is preferred for all infants and that breastfeeding be continued for a year for all infants.

The sample used in this study is typical for the data collection site but may not be typical for other geographical areas or hospitals even within the same region. Also, some ethnic groups may have been artificially excluded due to the inclusion criteria of being able to read and write in English. The demographic profile of the women using this hospital site is currently becoming an ethnically more diverse population related to current growth trends in the geographic area. The area has one of the highest growth rates in the state due to its newly acquired accessibility to New York City through recent road construction (Darragh, 2006).

Ethnicity may be an important variable to consider for replication studies since other studies support demographic variables such as age, ethnicity and culture as being

influential for women making healthcare choices in a variety of healthcare situations. Faria, Barrett and Goodman (2001) measured women's attitudes about choosing abortion and showed that white, older women with a higher educational and income levels had a more positive attitude about their decision as compared to younger, less educated women. Petrisek, Laliberte, Allen, and Mor (1997) investigated decision-making in women of different ages related to the breast cancer options they choose. Their findings indicated that younger women actively sought more information about their diagnosis compared to older women. Milligan et al. (2000) found that age was a significantly important variable when women decide on an infant feeding choice. Younger women chose bottle feeding as their infant feeding method more frequently than older women. Matthews et al. (1998) also found that ethnicity, independent from socioeconomic status, influenced infant feeding choice. Matthews showed a positive relationship between women's employment and bottle feeding. In this study, women that worked were more likely to bottle feed. Williams and Pan (1995) and Hawkins and Heard (2001) found that socioeconomic status and age influenced infant feeding choice separately from other variables. Younger and less financially secure women chose bottle feeding more often.

Research Questions

Research Question 1

Research Question 1 asked, "What are women's scores on emancipated decision-making and the five subconcepts of emancipated decision-making?" Mean scores of the EDMS subscales were all high, at or above the midpoint of 3.0 based on a 5-point Likert scale. All five subscales had a mean range of 3.5 to 4.3. Since all five concepts were rated

on the high end of the Likert scale in this study, it could be interpreted that women in this study were already using an emancipated decision-making process. Another consideration is that instrument bias contributed to the high scores.

Flexible environment.

On the EDMS, flexible environment had the highest mean score compared to the other four subconcepts. A flexible environment is one that can be emancipating because it respects and honors different types of knowledge including personal knowledge and knowledge gained from reflective practices (August-Brady, 2000). This subconcept may be one of the most important factors for nursing care consideration since it can be a modifiable factor in clinical care. Flexible environments can be produced by health professionals who provide unbiased information about healthcare alternatives. The high score on the flexible environment subscale may also have been a reflection of the nursing care unit that was studied. The nursing unit on which this study took place offered an equal number of daily education classes for both methods of infant feeding. This, in itself, may have produced a flexible environment because subjects and their families may have recognized that both methods, breastfeeding and bottle feeding, were given equitable educational opportunity. The influence of the overall environment including the health professionals and significant people such as the father of the baby, family and friends are often factors cited in many studies as having an influence on a woman's decision to breastfeed (Giugliani et al., 1994; Creed-Kanashiro, Cueto & Jacoby, 2005; Wambach & Koehn, 2004).

Had the environment been unsupportive of different infant feeding methods, the

scores in this study may have been decreased since the highest partiality to any one feeding method was less than 50% in this study. The assumption that the environment is an important factor in decision-making is supported by a study by O'Connor, Jacobson and Stacey (2002) which stated that one variable in decisional conflict is lack of support. Environmental support can also be conceptualized to include people in the woman's environment, such as significant people in her life as well as healthcare professionals. The O'Connor, Jacobson and Stacey study characterized lack of support as a modifiable factor. Future studies testing the Wittmann-Price Theory of EDM may consider modifying the clinical environment by implementing identified attributes of a flexible environment to further promote EDM such as providing equal education on all alternatives.

Personal knowledge.

Personal knowledge or the woman's ability to know what is innately best for herself and her infant, scored second highest of the subconcept means. This sample, due to their educational level, most likely had decided on what infant feeding method was best for them prior to entering the hospital. Some authors have found that infant feeding decisions are made far in advance of the infant's birth (Kieffer, Welch, Mor & Thiele, 1997; Reynolds, Joyner & Blankson, 1998; Swanson & Power, 2005). Therefore, it is feasible that the decision about infant feeding method, even if it was originally made using professional knowledge, was already made and incorporated into the woman's personal knowledge, which was then reflected in the personal knowledge subconcept scale.

Higher scores on personal knowledge may also indicate that a woman has enough self-awareness and also self-esteem to make a decision that is right for her. Bunn, O'Connor, Tansey, Jones and Stinson (1997) stated that self-efficacy, which is a concept related to self-esteem, is inversely related to decisional conflict. Blyth et al. (2004) supported self-efficacy as a factor needed to carry through an infant feeding decision. Bottorff (1990) also found a qualitative thread between self-efficacy and determination and Kessler et al. (1995) also suggested that self-efficacy is a strong indicator of a choice. Identifying, expanding and exploring the role of self-efficacy and its relationship to personal knowledge may further help refine the subconcept of personal knowledge.

Social norms.

Social norms, which can be verbally or nonverbally transmitted to the woman as the most acceptable choices in healthcare, scored the third highest mean. It would be unlikely for women in this study to be unaware of what choice in infant feeding methods is more socially accepted by the larger society due to the influence of the Healthy People 2010 campaign. Women are continually exposed to public information supporting a specific infant feeding alternative. This factor must be acknowledged on some level in the decision-making process regardless of whether the final choice was opposed to, or in favor of, the socially promoted choice (Bean, 2001; Earle, 2000; Hauck & Iruita, 2003; Lothian, 1998; Mazingo, Davis, Droppleman & Merideth, 2000; Swanson & Power, 2005).

Social norms may have influenced the study sample toward one feeding method, but regardless of the actual choice of infant feeding, the results revealed that social norms

were a significant factor in using an emancipated decision-making process. This supports the assumptions of the Wittmann-Price Theory of EDM that person and environment are intertwined and that social norms are embedded within the decision-making process.

Empowerment.

The sample studied may have had an innate sense of empowerment as shown by the mean above the possible mid-point in this subscale. This may be directly related to the homogeneous demographics of the sample. Since empowerment in this study was defined as information provided to the woman by healthcare professionals, the probability is that most of the study group had prior access to healthcare due to their income level and probably availed themselves to prenatal care and educational offerings. Studies support prenatal teaching as empowering or providing women with information about infant feeding method and therefore affects decision-making (Coombs et al., 1998; Giugliani et al., 1994; Handfield & Bell, 1995; Lothian, 1998; Martens, 2001; Wambach & Koehn, 2004).

The results of this study showed that empowerment is important for emancipated decision-making. This finding is consistent with those of other studies about women's healthcare decisions. Jairath and Kowal (1999) revealed that information was a significant variable in decision-making about post surgical pain management. Brown, Carroll, Boon and Marmoreo (2002) reviewed three separate qualitative studies about women's decision-making about healthcare issues and found that information seeking was a common theme in all three studies and therefore needs to be addressed. One of the ways in which it is being addressed is the current trend in decisional science to develop

decisional aids which provide the patient with tools that render information and assist the patient in weighing decisional outcomes (Drake, Engler-Todd, O'Connor, Surh, & Hunter, 1999; Sawka et al., 1998). Information giving has been shown to significantly decrease decisional anxiety (Goel, Sawka, Theil, Gort, & O'Connor, 2001). This study supported the theoretical premise that information provided to women from health professionals is an important factor in decision-making.

Reflection.

Reflection, related to thinking about the healthcare alternatives, presented by infant feeding choices may not have been a timely subconcept for this study causing it to score the lowest mean. Reflection may need to be measured earlier in the decision-making process for this exemplar. The thought process regarding infant feeding choices, as stated before, may have occurred long before this study was conducted (Williams et al., 1997; Wambach & Koehn, 2004) and if the decision was taken to another cognitive level, may have become part of a different concept, the woman's personal knowledge base. Dix (1991) pinpointed the time of infant feeding decision at six months gestation.

Also, reflective thinking inspired by dialogue with professional nurses may not be a feasible expectation in today's healthcare system. Professional nurses are in high demand and decreasing length of stay for mothers and their infants is a clinical norm. These factors decrease the available time for professional nurses to dialogue with women assigned to their care.

Reflective dialogue as a factor in decision-making requires further study and may need to be defined as a more formal process, or nursing intervention. Making reflective

dialogue a nursing priority for women making healthcare decisions may be needed in order for the professional nurses to be able to justify the time it takes to dialogue with their patients.

Research Question 2

Research Question 2 asked, “What are the relationships among the five subconcepts of emancipated decision-making and the total emancipated decision-making scores?” Pearson correlations of the five subscales of EDMS revealed that the subscales were significantly related to an emancipated decision-making process. The subconcepts were also significantly related to each other except reflection and social norms, and reflection and personal knowledge. Reflection, as defined in this study, is a separate and unique concept and this was supported statistically. Personal knowledge and flexible environment showed high multicollinearity as did personal knowledge and social norms.

Unrelated subconcepts: Reflection and social norms.

Social norms are influences that do not originate from within the person.

Reflection is a type of “thinking things through” by using dialogue with another or self-dialoguing and may be considered as an internal cognitive process. Groff et al. (2000) found that reflection was a strong variable in decision-making in a large ($N = 148$) qualitative study. Studies about decision-making in different nursing roles also supported the finding that reflection is a needed and unique component of decision-making. In recent literature, Williamson (2005) found that reflection increased effective decision-making in nursing management and Plack and Greenberg (2005) encouraged practitioners to become more reflective in order to enhance consistent decision-making. The findings

of this study indicate that social norms and reflection are two separate but needed subconcepts of EDM.

Unrelated subconcepts: Reflection and personal knowledge.

Reflection and personal knowledge are also unrelated concepts. Reflection may lead to personal knowledge but personal knowledge may not need to be derived from reflective thinking at the time a woman makes a decision. Reflection is a subconcept of EDM separate from personal knowledge. Results of this study do not implicate reflection as a prerequisite to personal knowledge.

Related concepts: Personal knowledge and flexible environment.

Personal knowledge and flexible environment showed high multicollinearity, therefore these two concepts, although operationally different, are relating similar information about the subjects' decision-making process. Thirty-two percent of the variance was shared between personal knowledge and flexible environment. This may be a result of the definition of flexible environment as an internal and external environment that is responsive and resilient to increased choices which enhance self-esteem and satisfaction (August-Brady, 2000). The internal component of flexible environment may take on the characteristics of personal knowledge which is also an internal process and a way of knowing that has components of self-awareness (Berragan, 1998). The definition of flexible environment as solely an external influence on a person may dissociate it from personal knowledge and make its characteristics easier to define but would render it inconsistent with the theoretical framework of the Wittmann-Price Theory of EDM. The high multicollinearity supports the concept as both an internal and external process and

supports the concept of person and environment as inseparable. This interpretation is consistent with other nursing theorists such as Leininger, Rogers, and Parse (Tomey & Alligood, 2002). Specific attributes of each subconcepts need to be differentiated in future studies.

Related concepts: Personal knowledge and social norms.

Personal knowledge and social norms also showed high multicollinearity and may be due to a similar internalization of external environmental influences as with personal knowledge and flexible environment. Although social norms may be conceptualized as a more expansive component than flexible environment there would be an integration of concepts from the macro environment or society into the micro or immediate environment of the woman involved in healthcare decision-making. These influences may be so strong or insidious that they are adapted as part of personal knowledge. Parse (1991) enforces this viewpoint by describing the environment as a human-universe-health process that can each be described but are ultimately linked in mutual process. This supports the Wittmann-Price Theory of EDM which theorizes that social norms may be internalized.

Research Question 3

Hypothesis 1 answered Questions 3, “What is the relationship between emancipated decision-making and satisfaction with the decision about infant feeding method in women? “ This hypothesis was accepted because the findings revealed a significant relationship between EDM and SWD ($r = .74$, $p < .001$). The correlation coefficient indicates a strong, positive relationship between EDM and SWD scores.

Women who use an emancipated decision-making process are more satisfied with the decision. This supports the underpinnings of the Wittmann-Price Theory of EDM by confirming that decisions that are made by free choice are more satisfying.

When each of the five subconcepts were tested for correlation with SWD the strongest single predictor was personal knowledge. This implicates personal knowledge as a concept that is important in decision-making and supports claims that it is a valid and important knowledge source for women (Pritchard, 2005; Sedlak et al., 2005). This study supports the operational definition of personal knowledge by indicating that higher scores in personal knowledge indicate women with self-awareness are satisfied with their decision.

Personal knowledge also has high multicollinearity with social norms and flexible environment and therefore support the finding of Research Question 2. Again this finding may be a result of the definition of personal knowledge as a way of knowing that has components of self-awareness (Berragan, 1998). This self-awareness may have incorporated information from micro and macro environments of the woman due to the inability to separate person and environment (Tomey & Alligood, 2002).

Research Question 4

Hypothesis 2 was addressed by Research Question 4, which asked “Does the combination of the subscales of emancipated decision-making (empowerment, flexible environment, personal knowledge, reflection and social norms) predict satisfaction with the decision about infant feeding method in women better than any one element alone?” Findings revealed that the combination of personal knowledge and flexible environment

explained 62.2% of the variance in SWD. Subjects who were satisfied with their decision seemed to have personal knowledge, or have an understanding of what was best for them, and were able to use it in their decision-making process because of the flexible environment.

The subconcept that explained the least amount of variance, and did not have a significant correlation with SWD, was reflection. There are three probable reasons; difficulty in reflecting in the clinical area related to time constraints, lack of nursing interventions fostering reflection in women, or the reflection took place at an earlier time and was difficult to elicit at the time of data collection.

Another consideration is that reflection was only tested by five items. This small number of items may have caused difficulty in operationalization of the subconcept of reflection in relation to satisfaction with the decision. The number of items does not completely explain the insignificance of reflection since empowerment had fewer items on the EDMS ($n = 3$) but was statistically significant to SWD ($p = < .05$). These results may indicate that the items elicited the subconcept of empowerment well and the items for reflection need to be reexamined. Flexible environment also had a low number of items on the EDMS ($n = 4$) but proved to correlate well with SWD ($p = < .001$) therefore the items operationalized the subconcept well. Social norms, a subconcept with 11 items, was significantly related to SWD, but failed to enter the regression analysis due to high multicollinearity with personal knowledge. Personal knowledge was the subconcept with the most items ($n = 12$) and therefore, may have biased the instrument towards higher correlations for that subconcept.

Additional Analyses

Additional analysis of the subjects' demographic data found that women who worked prior to the birth of their infant and women who intended to return to work after the birth of their infant were the only two demographic variables that revealed differences in the subjects' emancipated decision-making total scores. Being employed prior to delivery and intending to continue to work after the delivery was positively correlated with empowerment. One interpretation of this finding is that women who contribute to the financial support of the family feel they have increased emancipated decision-making capabilities. Being financial contributors to the family or financially independent, may be a factor for further study regarding emancipated decision-making. In many cultures, employment of the woman increases the status of the woman, thereby increasing her self esteem (Erci, 2003). This insight about the relationship of women and employment was not the initial intent of including this variable in the study. The initial intent was to evaluate work history as a factor in feeding choice related to convenience or financial benefit (Morse & Bottorff, 1989; Raisler, 2000; Rodriguez-Garcia, 1990; Williams, Innis, Vogel & Stephen, 1997). Therefore, employment of women can be interpreted as a variable that may produce two different attributes on two different levels for women. It can be a social enhancer related to the value placed on it by society which may have affected emancipated decision-making or it can be a practical consideration when making healthcare decisions related to time management and/or financial factors. Employment of women making healthcare decisions warrants further investigation.

Among subconcept intercorrelations, age was negatively related to empowerment.

Younger women felt more empowered. This finding also needs further investigation. Professionals may educate younger women differently and with different resources than mature or older women. Professionals may assume younger women, by virtue of their age and limited life experience, require more or different information and education and the woman finds this information empowering. Another explanation may be that younger women do not consider all the possible consequences of a decision and therefore take the information provided to them by healthcare professionals at face value and act on it in the decision-making process with less hesitation.

Other significant correlations were noted in additional analysis. Parity was negatively related to empowerment and reflection. Parity is defined as having other child(ren) at home, however, parity was not quantified by the number of children at home. A practical explanation for this may have to do with lack of time available for reflection and information gathering related to increased child care responsibility. Increased parity may also indicate increased maternal age which supports the same negative relationship between age and empowerment. This result makes a weak link between reflection and empowerment. The relationship was not directly tested but needs further study. Reflection and empowerment may be found to have a reciprocal relationship in emancipated decision-making. Reflectiveness may lead to empowerment and empowerment may lead a woman to reflect on information. Parity is often a cited variable in relation to choosing one infant feeding method over another (Barber et al., 1997; Kieffer, Welch & Thiele, 1997; Meyerink & Marquis, 2002; Milligan et al., 2000). Having more than one child alters a woman's responsibility and may increase her need to

tend to care issues which society deems “women’s work” and decreases her time for other responsibilities such as employment which some cultures may view as empowering. This is an area of concern for nursing if society does not recognize childrearing as an empowering position for women. Undermining the importance of these roles may culminate in difficulty in future generations. Reflecting on these issues with women may lead to further discovery of social norms and is well within the nurse’s role as educator, clinician and researcher.

Summary of Results in Relation to Nursing

The following sections will discuss the results related to theoretical development of the Wittmann-Price Theory of EDM and specific areas of nursing.

Theoretical Development

The concept of emancipated decision-making was derived from this researcher’s synthesis of specific concepts from Critical Social, Feminist and Freire’s Emancipatory Education theories to explain decision-making phenomena observed in clinical practice in women’s healthcare. Each foundational theory contributed a subconcept and reinforced the significance of a subconcept in the development of the Wittmann-Price Theory of EDM.

Critical Social Theory recognizes the relationship of society and individuals as inseparable. Critical Social Theory and Freire’s Emancipatory Education Theory recognize that oppression exists within social norms. Feminist theory recognizes societal oppression as inherent and specifically applied to women. Critical Social and Freire’s Emancipatory Education theories suggest that important subconcepts of emancipation are

reflection and personal knowledge. Feminist Theory further defines the need for empowerment through professional knowledge and the need for a flexible environment in order for women to reach an emancipated decision.

The results from this study supported all five subconcepts as important to emancipated decision-making. Flexible environment and personal knowledge were the strongest components of EDM. These two subconcepts are embedded in all three supporting theories. Critical Social and Freire's Emancipatory Education theories clearly call for an environment which does not intimidate people and supports free choice and equality. Feminist Theory, as well as Critical Social and Freire's Emancipatory Education theories support personal knowledge in the post constructionalist era of simultaneous action which acknowledges multiple ways of knowing and knowledge development (Berragan, 1998).

Flexible environment and personal knowledge may have been the strongest indicators of EDM by encompassing aspects of the other three subscales (empowerment, reflection and social norms) by multicollinearity. Empowerment, which was defined as professional information provided to women, may have been difficult to separate from personal knowledge because infant feeding decisions are often made early in the prenatal period. Empowerment may be a more evident subconcept in a decision which requires a decision in a shorter time frame. The information provided by professionals may not be readily recalled as a specific instance in the recent past if the information was presented at prenatal classes or was found in the abundant reading material that white, upper middle class, well-educated subjects are exposed to during routine prenatal care. Reflection, as

an internal awareness process of thinking about alternatives, may not have been differentiated as separate from personal knowledge in the subject's decision-making process regarding infant feeding method. Reflection may have also occurred at some point prior to the study and therefore was not readily revealed as a separate process within the time frame of the study.

Other considerations may include that not all women were oppressed in their decision-making and that the recognition of oppression may not have been fully realized in the subconcept of social norms. The later may have occurred for a number of reasons which have been previously cited in the literature and includes the researcher's, subject's or the environment's inability to recognize oppression towards women due to its profound integration in the system (Arslanian-Engoren, 2002; Holmes, 2002).

The results of this study indicate that emancipated decision-making is positively related to satisfaction with the decision suggests that there is still an underlying oppression in women's health that may correlate with a less satisfying decision-making process. Social norms may need to be redefined as an antecedent to EDM rather than an attribute for further theory development. Social norms may be more clearly linked with oppression and therefore, may not be as recognizable as a specific subconcept or a subconcept linked directly with a sanctioned alternative or choice in nursing practice. Swanson and Power (2005) studied subjective social norms ($N = 203$) and found that influence of social referents from family, partners and close friends were a determining factor in not continuing breastfeeding.

These results have strong implications to further study emancipated decision-

making by refining the subconcepts and exploring the relationship among the subconcepts. Different postulations and different exemplars may assist the theoretical development by leading to insights that can be more generalizable.

The Wittmann-Price Theory of Emancipated Decision-making (EDM)

The Wittmann-Price Theory of EDM assumes the environment is both an internal and an external component and an inseparable part of the person. The theory further assumes that oppression may be a factor in the environment and affects women's decision-making. These assumptions are supported by the fact that emancipation in decision-making is a theoretically sound but beginning construct. Emancipated decision-making recognizes and can reduce oppression thereby fostering relative freedom of choice because it supports freedom in decision-making and produces satisfaction with the decision.

Person

The theoretical definition of person as one who receives nursing care as a necessary component of their complex environment for the purpose of attaining or regaining emancipated healthcare decisions is the goal of this theoretical development. A person is in constant interaction with the environment as shown by both the subconcepts of flexible environment and social norms. Other factors that structure or affect a woman's social environment such as employment and responsibilities related to parity may need further consideration with this exemplar and possibly others.

Environment

Environment, in this theory, is a complex concept viewed as both internal and external factors that affect the person. The environment includes not only physical space, but also feelings and attitudes that surround and extend into the person as in the concept of flexible environment. Environment is not “time grounded”, but included decisions such as infant feeding method that may have been long term decisions related to gender upbringing. The environment includes a person’s interpretation of all past, present and future events. The environment includes culture and social factors that influence decision-making and each person’s interpretation of the totality of self and environment to uniquely find meaning in situations in an individualistic manner and transform that meaning into personal knowledge. Flexible environment and personal knowledge had a high correlation and further refinement of these two concepts is needed to make them distinct or blend them into one subconcept for future theoretical development. The high correlation adds support to the fact that a person and their environment are inseparable theoretical constructs. This study supports that environments can be flexible and therefore non flexible, meaning they can support an emancipated decision or impede an emancipated decision in women’s healthcare.

Health

Health as a culturally and socially defined phenomena that is valued and practiced, and has the ability to be satisfied by using an emancipating decision-making process was supported in this study. EDM maintains individuality in self by recognizing reflection and personal knowledge and recognizes the self as part of the environment

within the concepts of flexible environment, social norms and empowerment. This conclusion supports the theoretical constructs of other nursing theorists and is supported by the concept of “affiliated individualism” coined and defined by Erikson, Tomlin and Swain (1983) which states that humans “need to feel a deep sense of both the “I” and the “we” states of being and to perceive freedom and acceptance in both states” (p. 47).

Nursing

Nursing, as a science and art of purposeful interaction with a person, can promote and support emancipated decision-making in women’s healthcare. Nursing can support emancipated decision-making to promote self in a positive way which includes the physiological, psychological, spiritual and emotional aspects of the individual. The role of the nurse as facilitator, which provides the person with a flexible, empowering, reflective environment that recognizes social norms and personal knowledge, is in the beginning stages of development. Nursing care of women can have a great impact on the subconcepts of empowerment, reflection and flexible environment through specific interventions. Nursing can also recognize the influence of social norms and personal knowledge in the decision-making of women in their care.

Further theoretical development

Nursing interventions need to be tested to promote emancipated decision-making and call for further definition and refinement. This study has great implications for nursing and challenges nursing to develop the concept of flexible environment as a standard therapeutic nursing intervention. In order to do this, nursing needs to study environmental factors and the effect they have on women in the position of making

healthcare decisions. Nurses may need to evaluate their own personal knowledge in the context of healthcare choices in order to prevent biases about healthcare issues. Nurses must recognize oppression in the system in order to be able to overcome the constraints placed on them by social norms and consciously facilitate a flexible environment in order to allow women to use an emancipated decision-making process. Nurses may be able to assist or encourage patients to reflect and understand their personal knowledge through meaningful dialogue. The mechanisms, interventions and skills used to encourage reflection and development of personal knowledge as part of nursing care warrants further study as ways to provide a flexible environment and empower patients by education.

This study supports the assumption of the Wittmann-Price Theory of EDM in which the person and environment are in constant interaction. Environment included both external and internal components that are intertwined with social norms, both obvious and obscure. The refined theory may differentiate environment as that which is external to the person to better differentiate it conceptually to expand on defining flexibility in environments.

Environment can be used for positive or emancipating outcomes or negative or oppressive outcomes depending on the intent. A woman can achieve an emancipated decision by recognizing social norms within a flexible environment knowing that society may sanction one alternative as more acceptable than another. An emancipated decision-making process will be more satisfying to the woman. Other factors that promote an emancipated decision-making process are having information about the healthcare

alternatives from professional sources and reflecting on the decisional healthcare issue and choices.

The assumptions of the Wittmann-Price Theory of EDM.

1. There is an oppressive force originating internally or externally and it is recognized by women as an impingement upon free choice.
2. Oppression indicates that there is a power applied to a situation unequally because of gender, race, socio-economic status, culture, healthcare status, or differing biological functions of women.
3. Oppression in healthcare hinders women's freedom of choice about healthcare issues that directly affect them.
4. Women must recognize oppression as a state of disequilibria between what they want, or perceive as best for themselves, and what society perceives as best for them.

The propositions of the Wittmann-Price Theory of EDM.

1. Women are cognizant of oppressive powers that are present from internal or external sources that affect their decision-making process.
2. Women are empowered with the knowledge needed to understand or comprehend all the viable alternatives or choices of a decision.
3. Women use personal knowledge in conjunction with empowerment when making an emancipated decision.
4. Women have had the opportunity to use reflection to synthesize personal and professional knowledge to evaluate the alternatives.

5. The environment is flexible enough to support women's decisions without imposing further oppressions.

Summary of results related to the Wittmann-Price EDM.

The results of this study support that emancipated decision-making process by women can be accomplished when the identified subconcepts (empowerment, flexible environment, personal knowledge, reflection and social norms) are in place in the healthcare environment. This is demonstrated by the high scores on the EDMS in all areas. This study supports the proposition that women may be affected by oppression in the healthcare environment. The development of this theory would further benefit from studying the degree of awareness women have of their social responsibility to themselves, family, community and larger society when making healthcare decisions for themselves and family members since studies show that women make the majority of family healthcare decisions (O'Connor, Jacobson & Stacey, 2002).

This researcher posited that the Wittmann-Price Theory of EDM promotes positive patient outcomes by supporting an emancipated decision-making process as a modality to increase woman satisfaction with decisions. EDM is one mechanism to foster individualism and freedom, two innate and important human aspects within the realm of healthcare.

Outcomes of an emancipation decision-making process.

1. The decision reflects an issue relevant to society in the healthcare of women.
2. The decision is a reasonable and viable solution to a choice.

3. Women make decisions without coercion.
4. Women arrive at a decision after reflection.
5. The decision is perceived by women as satisfying.
6. The decision is perceived as a more positive state of being.

Nursing Implications

Clinical Practice

This study findings have has implications for clinical practice in women's healthcare. Nursing care can influence women's decision-making in the postpartum hospitalized period (Bernaix, 2000; Hoddinott & Pill, 2000). All women in healthcare situations, facing healthcare choices, are in a vulnerable position. Social influences can either provide the flexible environment needed for the women to make an emancipated decision, or can produce oppression by sanctioning one option as better than another in a ridged or nonflexible environment. Nurses need to understand their personal biases about specific women's healthcare issues in order to refrain from unconsciously creating a nonflexible environment, and thereby influencing the woman's decision-making. Nurses also need to recognize that oppression still exists and may influence how satisfied a woman is with her healthcare decision (Allen, 1985).

Nurses are in a professional position to foster reflection. The mechanism by which this intervention is accomplished may need further investigation but may include dialogue. Nurses need to recognize personal knowledge as a valid knowledge source and one that will lead women to emancipated decision-making. Table 11 presents an

exemplar of a nursing care plan derived from the results of this study to enhance women's emancipated decision-making about healthcare issues.

Nursing Education

Educational systems must be considered an important micro system of society (Freire, 1970). Recognizing the educational system as an influential component of the social system is paramount for nurse educators to understand because the environments they create with students may effect the environment of students' future clinical practice. Nurse educators must value the personal knowledge of students. Personal knowledge has a direct influence on the learning of the student and is an inseparable part of the students' evolution. An emancipated environment for learning has been proposed as a nursing curriculum and is essential in developing the caring aspect of the discipline that sets nursing apart from other healthcare professions (Bevis & Watson, 1989; Diekelmann, 2003, Jacobs, Fontanan, Kehoe, Matarese & Chinn, 2005).

Nursing Research

The Wittmann-Price EDMS has contributed to the development of instruments for nursing research. It has been validated and is reliable at an alpha of .89. It is specific to infant feeding method but the wording can be adjusted for other women's healthcare decisions. The EDMS, as a 35-item, tool is useable in the clinical area. It is easy to rate and score. This study has also repeated reliability on the already established SWD scale.

Table 11.

Nursing Care Plan to Promote an Emancipated Decision-making Process in Women's Healthcare.

Nursing diagnosis:

Ineffective emancipated decision-making process related to constraining social norms, lack of empowerment, inflexible environment, lack of awareness of personal knowledge or lack of reflection as seen by dissatisfaction with the decision-making process.

Short term goals:

1. Encourage an emancipated decision-making process by dialoguing about any decisional dilemmas produced by healthcare alternatives.
2. Empower the patient by providing unbiased information about all possible alternatives.
3. Provide a flexible environment for the patient to reflect openly about healthcare alternatives.
4. Assist the patient to reflect on feelings through therapeutic communication.
5. Assist the patient to formalize personal knowledge about the way each alternative would affect her by encouraging dialogue.

Long term goal:

Increase patient's satisfaction with her decision by promoting emancipated decision-making.

Further Development

Further theoretical development is needed both qualitatively and quantitatively. Qualitative investigation of all five subconcepts may further refine the operational definitions and context use of each subconcept. This study warrants a repeat study in a more diverse sample population. Other exemplars need to be tested in order to support the generalization of the theory to other perinatal and women's healthcare issues.

Limitations of Generalizability of Results

This study is limited in generalizability by virtue of the population studied and exemplar used. The sample was white, middle upper class, well-educated women and the results may not be generalizable to other populations of women. Other limitations inherent in this study may arise from the definitions and understanding of the subconcepts and the multicollinearity of EDMS subscores.

Another issue that may have affected the results of this study was institutional policy that allowed unlimited visiting hours thereby decreasing the women's privacy when participating in the study. The influence of another person or other people in the room could not be controlled during data collection.

Conclusions of the Study

The following conclusions were derived from the findings of this study:

1. Emancipated decision-making scores for on all five subscales on the EDMS were high, or above the midpoint.
2. EDM scores and SWD scores were significantly and positively related.
3. Women used an emancipated decision-making process based on empowerment,

flexible environment, personal knowledge, reflection and social norms.

4. Women who used an emancipated decision-making process were more satisfied with the decision.
5. Personal knowledge and flexible environment were the most significant subconcepts for women making an emancipated decision.
6. Women who worked before the birth of their infant had higher emancipated decision-making total scores.
7. Women who planned to continue working after the birth of their infant had higher emancipated decision-making total scores.
8. The subconcepts of personal knowledge and flexible environment were the best predictors of SWD.
9. Age is negatively related to empowerment.
10. Parity is negatively related to empowerment and reflection.
11. The Emancipated Decision-making Scale (EDMS) is a reliable instrument.
12. The Satisfaction with Decision (SWD) scale is a reliable instrument.
13. The EDMS may be biased towards high emancipated decision-making total scores.

Recommendation for Future Research

The following recommendations for future research studies about emancipated decision-making are:

1. Consider other variables that were not included in this study, such as, personal values and the timeframe in which a decision is made.

2. Use qualitative investigation to further define the subconcepts and identify other subconcepts that may be involved in an emancipated decision.
3. Study demographic variables such as employment, age, and parity in relation to emancipated decision-making in other clinical exemplars which may include but are not limited to the list under number 8.
4. Future development of the Wittmann-Price Theory of EDM needs to focus on retesting the theoretically derived subconcepts in other populations of women and with other healthcare exemplars.
5. Nursing education must critically explore teaching/learning strategies that encourage emancipated decision-making by nursing students.
6. Further testing of the EDMS in larger and more culturally diverse populations of women.
7. Studying the extent that nursing curricula include decisional science as a content topic may also promote discovery of curriculum alterations and enhancements.
8. Other possible exemplars in women's health that call for a personal decision are:
 - a. Twenty-four hour rooming-in.
 - b. Pain management alternatives in labor.
 - c. Family-centered care.
 - d. Circumcision of the male infant.
 - e. Lumpectomy vs. mastectomy for breast cancer.
 - f. Hormone replacement therapy for menopausal symptoms.

Developing the professional nurse as more than a patient advocate, as an

emancipator, who respects the personal knowledge of women, who understands that oppression insidiously exists in the healthcare of women, and who can provide women with flexible, open, caring environment in which to make healthcare decisions is the ultimate future implication of this study. This implication can be realized by the ongoing development of the Wittmann-Price Theory of EDM in women's healthcare.

Chapter Summary

Chapter 5 has presented the conclusions of this study and the implications the study has to further nursing knowledge. Emancipated decision-making is a beginning practice theory that needs further investigation. The preliminary investigation has identified subconcepts that support emancipated decision-making in women's healthcare. Those subconcepts are a flexible environment and personal knowledge. Variables have also been identified that increase decisional satisfaction. Those subconcepts include a flexible environment and empowerment. Demographic variables that increase emancipated decision-making are the employment status of the women. Demographic variables that do not support the subconcept of empowerment are increased parity and decreased age. Increased parity also does not support reflection as a subconcept of emancipated decision-making. Future studies of emancipated decision-making need to be implemented to verify the variables or subconcepts with other clinical exemplars representing healthcare decisions for women. The study also warrants expansion to different populations of women to further investigate if the Wittmann-Price Theory of EDM is applicable to women of different ages, cultures and socioeconomic situations.

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Appendix A: Subject Demographic Questionnaire (SDQ)

Wittmann-Price Emancipated Decision-making

DIRECTIONS: Please answer each question in the space provided or place an **X** in the enclosed parentheses.

<p>1. Age in years _____</p>	<p>2. How would you describe yourself? <input type="checkbox"/> White <input type="checkbox"/> African American / Black <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian / Pacific Islander <input type="checkbox"/> Other _____</p>
<p>3. What language do you speak most of the time? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify) _____</p>	<p>4. Are you comfortable reading English? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>5. What level of education did you complete? <input type="checkbox"/> Some high school <input type="checkbox"/> Completed high school <input type="checkbox"/> Some college <input type="checkbox"/> College degree <input type="checkbox"/> Some graduate education <input type="checkbox"/> Graduate degree</p>	<p>6. Describe your living arrangements. <input type="checkbox"/> I live alone <input type="checkbox"/> I live with the father of the baby <input type="checkbox"/> I live with a same sex partner. <input type="checkbox"/> I live relatives/family. <input type="checkbox"/> I live with friends (unrelated). <input type="checkbox"/> Other arrangements (describe) _____</p>

<p>7. Did you work outside the house while pregnant with this baby?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>8. Do you plan on returning to work?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, when _____</p>
<p>9. Estimate your household yearly income level:</p> <p><input type="checkbox"/> below 15,000</p> <p><input type="checkbox"/> 15,000 to 30,000</p> <p><input type="checkbox"/> 31,000 to 45,000</p> <p><input type="checkbox"/> 46,000 to 60,000</p> <p><input type="checkbox"/> 61,000 to 75,000</p> <p><input type="checkbox"/> above 75,000</p>	<p>10. Have you ever had breast surgery?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, If yes what kind of surgery?</p> <p><input type="checkbox"/> Breast implants</p> <p><input type="checkbox"/> Breast reduction</p> <p><input type="checkbox"/> Breast cancer</p>
<p>11. How many other children do you have? _____</p>	<p>12. If you have other children, how did you feed them?</p> <p><input type="checkbox"/> breastfeed only</p> <p><input type="checkbox"/> bottle feed only</p> <p><input type="checkbox"/> both breast and bottle feed</p>
<p>13. Were you able to feed your new baby the first day after birth?</p> <p><input type="checkbox"/> yes</p> <p><input type="checkbox"/> no, If no, why not? _____</p>	<p>14. How are you feeding your baby?</p> <p><input type="checkbox"/> Breastfeeding only (I have not given the baby any bottles)</p> <p><input type="checkbox"/> Bottle feeding only (I am not offering the baby my breast)</p> <p><input type="checkbox"/> Breastfeeding at least 50% of the feeding time in the last 24 hours as well as given the baby bottle supplements</p>
<p>15. How do you plan to feed this baby at home?</p> <p><input type="checkbox"/> breastfeed only <input type="checkbox"/> bottle feed only <input type="checkbox"/> both breast and bottle feed</p>	

Appendix B: Introductory Letter to Experts for Validity.

Dear Dr _____,

I am a Doctor of Nursing Science (DNSc) candidate at Widener University School of Nursing. I am also an experienced nurse educator in the area of women's health. As part of my doctoral dissertation research concerning emancipated decision-making in women's healthcare, I am developing a Likert Scale questionnaire to measure the concept of emancipation within a newly developed theory of emancipated decision-making for women. The preliminary list of 50 items was developed based on a review of the literature, and other decision-making instruments, and the theoretical components being measured. Emancipated decision-making is conceptualized as a composite of five sub-concepts which are reflected in the five sub-scales of the instrument. While the general concept under consideration for measurement is emancipated decision-making, the instrument's statements are framed within the clinical context of maternal choice of infant feeding.

Because of your expertise in the area of decision-making, I would greatly appreciate your assistance in evaluating the content validity of the proposed questionnaire developed to measure the sub-scales of emancipated decision-making. Attached is a list of the statements that reflect the 5 sub-concepts of emancipated decision-making. Please indicate how relevant you think each item is in measuring emancipated decision-making, as well as the sub-scale it addresses. Also, any suggestions for additional items or comments you might care to make are most welcome.

A self-addressed envelope is enclosed for your convenience. Your co-operation in completing and returning your evaluation of the instrument by March 15th is requested.

I realize that the demands on your time and energy are great. I do appreciate your taking the time to respond to my request for your expert advice. If you would like to receive a copy of the final Wittmann-Price Theory of Emancipated Decision-making Scale with validity and reliability data, I will be pleased to send it to you this summer. Please indicate your choice at the end of the questionnaire.

Thank you for your time and co-operation.

Sincerely,

Ruth Wittmann-Price, RN, MSN, DNSc (candidate)

Appendix C: Expert Survey for Instrument Validation.

Measuring Emancipated Decision-making

Developed by Ruth Wittmann-Price, RN, MSN, DNSc (candidate)

DIRECTIONS: The statements below have been selected to measure the following 5 sub-scales of emancipated decision making. Please consider each item and judge its degree of relevancy with the 4-point scale provided, and indicate (X) which sub-scale it best represents. The clinical exemplar to explore the concept of emancipated decision-making is infant feeding method and the questionnaire is designed from the mother's retrospective view in the post partum period. The definitions of emancipated decision-making and its 5 sub-concepts are provided below.

Emancipated decision-making is a process of reaching a more positive state of being, a state of relative freedom in choice, by first acknowledging an affective experience of oppression. The experience is cognitively reflected upon, with or without dialogue. The choice is arrived at by using personal knowledge in combination with empowerment from professional knowledge. The decision is made in a flexible environment and precipitates the desired outcome of free choice.

Sub-scales:

- a.) Empowerment is the process that provides the resources, tools, and environment to develop, build, and increase ability and effectiveness of others to set and reach goals for individual and social needs (Hokanson-Hawks, 1992, p. 610). For the purposes of this measurement instrument, empowerment is the provision of information to women about healthcare alternatives by healthcare professionals.
- b.) Personal knowledge is a type of knowledge that has components of self-awareness. It is both subjective and objective and is described as the ability to understand one's self. Personal knowledge influences everything one does because it is being aware of one's own personal feelings (Berragan, 1998). For the purposes of this measurement instrument, personal knowledge reflects a woman's awareness of how various healthcare alternatives will affect her in her current situation.
- c.) Social norms refer to a woman's awareness that the external environment has sanctioned one of the possible alternatives in a decision-making situation as more acceptable than another. It originates as recognizing that knowledge development always occurs in a social context. That social context is capable of exerting power and influence over knowledge thereby influencing individual perception

(Berragan, 1998). For the purposes of this measurement instrument, social norms will be defined as an awareness of society’s sanctioning of the alternatives being considered.

- d.) Reflection is a technique that encourages critical thought either with oneself (self-dialogue) or another individual or group (dialogue) (Shor, 1989). It is a critical thinking process that assists the woman to develop the learning technique of “knowing thyself”. It is a self-analytical process that surfaces contradiction between what one intends to achieve in any given situation and the way one is behaving (Johns, 1999). It considers both the person and the situation (Penney & Warelow, 1999). For the purposes of this measurement instrument, reflection is defined as a cognitive or interactive process a woman has engaged in when considering alternatives.
- e.) Flexible environment is one that is responsive and resilient to change leading to personal benefits for the individual as well as increased choices which enhance self-esteem and understanding (August-Brady, 2000). For the purposes of this measurement instrument, flexible environment will be defined as an environment that allows unopposed enactment of any choice made by the woman.

Degree of relevancy scale: 1 = Not relevant
 2 = Somewhat Relevant
 3 = Quite Relevant
 4 = Very Relevant

Statement	Degree of Relevance				Sub Scales				
	1	2	3	4	Empowerment	Personal knowledge	Social norms	Reflection	Flexible environment
1. I thought, for a long time, about the way I would feed my baby.									
2. I have discussed the way I am feeding my baby with my doctor.									
3. I have discussed the way I am feeding my baby with a nurse.									

Degree of relevancy scale: 1 = Not relevant
 2 = Somewhat Relevant
 3 = Quite Relevant
 4 = Very Relevant

	1	2	3	4	Empowerment	Personal knowledge	Social norms	Reflection	Flexible environment
33. There were people available to me in the hospital if I needed help feeding my baby.									
34. I was given clear information with the pros and cons of each method of feeding by nurses and/or doctors.									
35. The way I am feeding my baby sometimes produces negative reactions from my friends.									
36. I spent a lot of time on my feeding decision.									
37. I looked for information myself about the feeding method I chose.									
38. The way I am feeding my baby sometimes produces negative reactions from my family.									
39. I was given information about all the different feeding options.									
40. The baby's father is happy about the way I am feeding my baby.									
41. The best way to feed is the way I am feeding my baby.									

Appendix D. Tally of Expert Opinion.

Degree of relevancy scale: 1 = Not relevant
 2 = Somewhat Relevant
 3 = Quite Relevant
 4 = Very Relevant

Statement	Degree of Relevance				Sub Scales				
	1	2	3	4	<i>Empowerment</i>	<i>Personal knowledge</i>	<i>Social norms</i>	<i>Reflection</i>	<i>Flexible environment</i>
1. I thought, for a long time, about the way I would feed my baby.			3	1 2 4 5				1 2 3 4 5	
2. I have discussed the way I am feeding my baby with my doctor.			1 3	2 4 5	1 2 5			3 4	
3. I have discussed the way I am feeding my baby with a nurse.			1 3	2 4 5	1 2 5			3 4	
4. I believe all the options for feeding my baby (breast, bottle or breastfeeding with bottle supplement) are OK.		3	5	1 2 4	2	1 3 4 5			
5. I decided on feeding my baby this way after talking it over in depth with a health professional.		3	1	2 4 5	1 2 3	5		4	

6. I feel guilty about the way I am feeding my baby.		1 5	3 4	2 4			1 2 3 5	4	
7. I have discussed the way I am feeding my baby with my family members.			1 4 5	2 3 4 5		3	1 2 5	4	
8. I was given information mostly about one feeding method.		1 5	2 4	3 4 4	2	5	1		3
9. The feeding method I have chosen is the one I think most women chose.		3		1 2 4 5			1 2 3 4 5		
10. My choice of feeding method was made based on pressure from others in my life.		1		2 3 4 5	1		2 4 5		3
11. The way I am feeding my baby is the best option for me.				1 2 3 4 5		1 4 5		2 3	
12. The hospital nurses helped me feed my baby.			1 4 5	2 3 4 5	3 4				1 2 5
13. The way I am feeding my baby makes everyone in my life happy.			1 5	2 3		1 4	2 3		

			4 5			5		
14. If I had to choose again I would pick the same feeding method.		3	1 2 4 5		2		1 3 4 5	
15. I felt pressure from health professionals to choose the feeding method I am using.		1	2 3 4 5		5	1 2 4		3 *suggested to reverse item
16. The hospital environment made it easy for me to feed my baby the way I chose.			1 2 3 4 5					1 2 3 4 5
17. The way I am feeding my baby fits my lifestyle.			1 2 3 4 5		1 2 3 4 5			
18. I put a lot of thought into how I was going to feed my baby.			1 2 3 4 5		3		1 2 4 5	
19. The way I am feeding my baby suits me personally.			1 2 3 4 5		1 2 3 4 5			

20. I decided on feeding my baby this way after talking it over in depth with someone who cares about me.		1 5	2 4	3 4	1		5	2 3 4	
21. The way I chose to feed my baby is the best way to feed a baby.		3	1 2	4 5		1 3 5	2	4	
22. I feel the way I am feeding my baby sometimes produces negative reactions from the nurses and/or doctors.		1		2 3 4 5			1 2 3 4 5		
23. I have discussed the way I am feeding my baby with my friends.		1	3 5	2 4			5	2 3 4	1
24. I always knew I would end up feeding my baby this way.	5		1 3	2 4		1 2 3 4 5			
25. I have thought about how I feed my baby will affect my life.			1	2 3 4 5		2 3 5		1 4	
26. I put pressure on myself to feed my baby this way.		1 5	2 3	4			1 2 4	3 5	
27. I choose the way I am feeding my baby without pressure from anyone else.			3	1 2 4				4 5	1 2 3

			5					
28. The choice I made about how to feed my baby is the best one for me.		1	2 3 4 5		1 2 3 4 5			
29. Everyone has been supportive in helping me feed my baby.		5	1 2 3 4					1 2 3 4 5
30. The way I am feeding my baby is the best option for my baby.		2 3	1 4 5		1 2 3 4 5			
31. I have discussed the way I am feeding baby with the baby's father.		1	2 3 4 5		1		2 3 4 5	
32. I think the hospital unit's routine helped me to maintain my choice of how to feed my baby.			1 2 3 4 5					1 2 3 4 5
33. There were people available to me in the hospital if I needed help feeding my baby.	1	3	2 4 5	3				1 2 4 5
34. I was given clear information		1	2	1				

with the pros and cons of each method of feeding by nurses and/or doctors.			3 4 5	2 3 4 5					
35. The way I am feeding my baby sometimes produces negative reactions from my friends.		1 5	3 4	2 4			1 2 3 4 5		
36. I spent a lot of time on my feeding decision.				1 2 3 4 5	1 5			2 3 4	
37. I looked for information myself about the feeding method I chose.			1 3 4 5	2 3 4 5	*1 left blank 2 5			3 4	
38. The way I am feeding my baby sometimes produces negative reactions from my family.		1 5	3 5	2 4			1 2 3 4 5		
39. I was given information about all the different feeding options.			1 3	2 4 5	1 2 4 5				3
40. The baby's father is happy about the way I am feeding my baby.		3	1 2	4 5			2 4 5		1 3

41. The best way to feed is the way I am feeding my baby.			2 3	1 4 5		1 3 4 5	2		
42. Too much emphasis is placed on the way babies are fed.		1	2 3	4 5	5		1 2 3 4		
43. I enjoy feeding my baby.		2		1 3 4 5		2 3 5		1 4	
44. I enjoy just being with my baby more than feeding my baby.	5	2	1 3	4		2 3		1 4 5	
45. I will stick to the feeding method I am using.		2	1 3 5	4		1 2 3 4			
46. My family supports my feeding decision.				1 2 3 4 5			1 4 5		2 3
47. It was easy for me to decide how to feed my baby.		2 3	1	4 5		1 2 4		3 5	
48. The information I was given about feeding my baby was adequate.		3 5	1	2 4	1 2 3				

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Memorandum

To: Ruth Wittmann-Price, RN, MSN

From: Dr. Barbara Patterson
Chairperson, Widener University Institutional Review Board

Date: July 22, 2004

RE: Protection of Rights of Human Subjects Review

This letter serves to inform you that your research, "Exploring the Elements of the Wittmann-Price theory of Emancipated Decision-Making in Women's Health Care using Infant Feeding Methods as the Clinical Exemplar: A Pilot Study" has been reviewed and approved by the Widener University Institutional Review Board (IRB) for the protection of rights of human subjects. You may begin data collection as proposed in your application.

If, for any reason, the approved research data collection method changes significantly, you are required to notify the IRB, in writing, of such changes. Please, remember that the IRB committee and Widener University accept no responsibility for liabilities associated with this study. Ultimately, responsibility rests with the investigator.

The approval of this study is in effect for one year from the date of approval and is eligible at that time for renewal. Upon completion of the study, a final written report of the research is to be submitted to the IRB.

The members of the IRB extend their best wishes for your successful completion of this research project. If you have any questions, please call me at [REDACTED] Thank you.

[REDACTED]
Barbara Patterson, PhD, RN

Cc: Dr. Lois Allen

Founded 1821
o One University Place, Chester, PA 19013-5792
o 3800 Vartan Way, P.O. Box 69382, Harrisburg, Pennsylvania 17106-9382



801 Ostrum Street
Bethlehem, PA 18015
610-954-4000
Institutional Review Board
Department of Medical Affairs
610-954-4944
<http://medaffairs.slhn.org>

August 12, 2004

Ruth Wittmann-Price
[REDACTED]

RE: Instrument Development - The Wittmann-Price Decision-Making Scale - SLHN 2004-30

Dear Ms. Wittmann-Price:

The IRB Office has received your application for IRB Approval dated August 10, 2004, for the protocol referenced above from the Research Evaluation Committee.

After reading this research protocol it has been determined that it is not necessary for it to be reviewed by the IRB because it does not fall under FDA regulations and it is exempt per the OHRP regulation §46.101b(2) which states exempt research includes:

Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

You may therefore pursue conducting this study as written.

Please note:

Any changes that you may wish to make to this protocol must be submitted to the IRB Office prior to implementing. The IRB Office will determine if the changes will effect the protocol's exemption status and then respond to you, in writing.

St. Luke's Hospital & Health Network has a Federalwide Assurance [FWA 00003557] from OHRP. The Institutional Review Board is registered with OHRP [IRB 00002757] and is in compliance with 45 CFR 46, 21 CFR 50 and 21 CFR 56. To the extent these Federal regulations are in agreement with the ICH Guidelines, we are also in GCP compliance.

If you have any questions regarding this or other IRB issues please feel free to contact me, at 610-954-4669.

Sincerely,

[REDACTED]

Manny Changalis, MS, CIP
Assistant Vice President
Medical & Academic Affairs

Please indicate your acknowledgment of this letter by signing below and returning one copy in the enclosed self-addressed envelope.

[REDACTED]

Ruth Wittmann-Price

Aug 16 2004
Date

Big-city medicine. Hometown care.

Appendix G: Letter of Introduction and Explanation of the Study.

Letter to Explain Study

To: New Mothers
From: Ruth Wittmann-Price, MSN, RN
School of Nursing, Widener University, Chester, PA 19013

I am a RN in school for my doctorate and I am looking at how women make decisions about healthcare. I have been a maternity nurse for 27 year and am asking you to help me finish my study by filling out a survey. Most of the questions on the survey are about how you chose to feed your baby. Also, there are questions about you and 6 questions about how satisfied you feel with your feeding choice. Your help in this study is voluntary and your survey will be anonymous. Please do not put your name on it.

The results of this study will help nurses to better understand how women make healthcare choices. The survey can be done anytime in the next 48 hours. It will take about 20 minutes of your time. When it is done, please put your survey in the envelope and seal it. Place the envelope in the labeled blue box on the chart rack by the nurses' station.

Your choice whether or not to help in this study will not affect the care you or your baby get in any way. Also, you can choose to stop filling out the survey at any time. You will not receive any pay for your help in this study.

While this study will not help you directly, the results of this study will help nurses learn about how women make decisions. There is a small risk that some of the questions on the survey may cause you to feel upset. This may happen if the decision about how to feed your baby was hard for you to make. If you get upset, just stop filling out the survey and place it in the envelope unfinished.

All of the surveys will be stored in a locked file cabinet in my office. Your name will not be used on any of the information. Only group information will be looked at and written about.

If you would like a write up about this study or have any questions about this study, please call me at [REDACTED]. Or you can email me at [REDACTED]. If you have any questions about your rights, please call Dr. Barbara Patterson, Chairperson, Widener University Institutional Review Board at [REDACTED].

Thank you again for your help in this study.

Appendix H: Wittmann-Price Emancipated Decision-making Scale (EDMS)

Please respond to the following statements concerning your decision about your infant's feeding method.

Indicate your answer by circling the number that represents how true each statement is for you **AT THIS TIME**.

STATEMENTS:	1 strongly disagree	2 disagree	3 neither agree nor disagree	4 agree	5 strongly agree
1. I have discussed the way I am feeding my baby with a nurse.	1	2	3	4	5
2. I decided on feeding my baby this way after talking it over in depth with a health professional.	1	2	3	4	5
3. The feeding method I have chosen is the one I think most women chose.	1	2	3	4	5
4. My choice of feeding method was made based on pressure from others in my life.	1	2	3	4	5
5. The way I am feeding my baby is the best option for me.	1	2	3	4	5
6. The way I am feeding my baby makes everyone in my life happy.	1	2	3	4	5
7. I felt pressure from health professionals to choose the feeding method I am using.	1	2	3	4	5
8. The way I am feeding my baby fits my lifestyle.	1	2	3	4	5
9. I put a lot of thought into how I was going to feed my baby.	1	2	3	4	5
10. The way I am feeding my baby suits me personally.	1	2	3	4	5

STATEMENTS:	1 strongly disagree	2 disagree	3 neither agree nor disagree	4 agree	5 strongly agree
11. I decided on feeding my baby this way after talking it over in depth with someone who cares about me.	1	2	3	4	5
12. The way I chose to feed my baby is the best way to feed a baby.	1	2	3	4	5
13. I feel the way I am feeding my baby sometimes produces negative reactions from the nurses and/or doctors.	1	2	3	4	5
14. I always knew I would end up feeding my baby this way.	1	2	3	4	5
15. I put pressure on myself to feed my baby this way.	1	2	3	4	5
16. I choose the way I am feeding my baby without pressure from anyone else.	1	2	3	4	5
17. The choice I made about how to feed my baby is the best one for me.	1	2	3	4	5
18. Everyone has been supportive in helping me feed my baby.	1	2	3	4	5
19. The way I am feeding my baby is the best option for my baby.	1	2	3	4	5
20. I have discussed the way I am feeding baby with the baby's father.	1	2	3	4	5
21. I think the hospital unit's routine helped me to maintain my choice of how to feed my baby.	1	2	3	4	5
22. There were people available to me in the hospital if I needed help feeding my baby.	1	2	3	4	5

STATEMENTS:	1 strongly disagree	2 disagree	3 neither agree nor disagree	4 agree	5 strongly agree
23. The way I am feeding my baby sometimes produces negative reactions from my friends.	1	2	3	4	5
24. I spent a lot of time on my feeding decision.	1	2	3	4	5
25. The way I am feeding my baby sometimes produces negative reactions from my family.	1	2	3	4	5
26. The baby's father is happy about the way I am feeding my baby.	1	2	3	4	5
27. The best way to feed is the way I am feeding my baby.	1	2	3	4	5
28. I enjoy feeding my baby.	1	2	3	4	5
29. I enjoy just being with my baby more than feeding my baby.	1	2	3	4	5
30. I will stick to the feeding method I am using.	1	3	3	4	5
31. My family supports my feeding decision.	1	2	3	4	5
32. It was easy for me to decide how to feed my baby.	1	2	3	4	5
33. The information I was given about feeding my baby was adequate.	1	2	3	4	5
34. Feeding my baby this way feels natural to me.	1	2	3	4	5
35. Feeding my baby this way is very important to me.	1	2	3	4	5

Appendix I: Satisfaction with Decision Scale (SWD)

Please answer the following questions about your decision about your infant's feeding method. Indicate your answer by circling the number that represents how true each statement is for you **AT THIS TIME**.

	1 strongly disagree	2 disagree	3 neither agree nor disagree	4 agree	5 strongly agree
1. I am satisfied that I am adequately informed about the issues important to my decision.	1	2	3	4	5
2. The decision made was the best decision possible for me personally.	1	2	3	4	5
3. I am satisfied that my decision was consistent with my personal values.	1	2	3	4	5
4. I expect to successfully carry out (or to continue to carry out) the decision I made.	1	2	3	4	5
5. I am satisfied that this was my decision to make.	1	2	3	4	5
6. I am satisfied with my decision.	1	2	3	4	5

You are welcome to use it. I would appreciate seeing at least an abstract of your dissertation results and/or publications when you have them.

Margaret Holmes-Rovner

From: Ruth Wittmann-Price [mailto: [REDACTED]]
Sent: Mon 10/18/2004 12:42 PM
To: Margaret HolmesRovner
Cc: Lois R Allen
Subject: Permission to use SWD Questionnaire

October 18, 2004

Margaret Holmes-Rovner, Ph.D.
Professor and Chief, health services Research
Department of Medicine
Michigan state University
B213 Clinical Center
East Lansing, MI 48824

Dear Dr. Homes-Rovner,

I would like permission to use the Satisfaction with Decision Questionnaire as one of three instruments in my doctoral study. I am testing emancipated decision-making in women's health care using a non life threatening exemplar, infant feeding method. I have developed a demographic questionnaire and an emancipated decision-making questionnaire to explore the sub concepts I have identified in emancipated decision making, reflection, personal knowledge, flexible environment, empowerment and social norms. The SWD questionnaire will assist me in determining if women are making decisions by free choice or under oppression. An emancipated decision-making process should correlate with a higher score of satisfaction with the decision.

Please let me know if you would like any further information to assist in your decision. Thank you for the consideration, I will be delighted to share with you a summary of the results at the completion of my study.

Respectfully,

Ruth Wittmann-Price

Enclosures:

Demographic questionnaire

Emancipated Decision-Making Questionnaire

Concept analysis article

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o 717-541-1932
Fax: 717-541-1977

Memorandum

To: Ruth Wittmann-Price, RN, MSN

From: Dr. Barbara Patterson
Chairperson, Widener University Institutional Review Board

Date: July 22, 2004

RE: Protection of Rights of Human Subjects Review

This letter serves to inform you that your research, "Exploring the Elements of the Wittmann-Price theory of Emancipated Decision-Making in Women's Health Care using Infant Feeding Methods as the Clinical Exemplar: A Pilot Study" has been reviewed and approved by the Widener University Institutional Review Board (IRB) for the protection of rights of human subjects. You may begin data collection as proposed in your application.

If, for any reason, the approved research data collection method changes significantly, you are required to notify the IRB, in writing, of such changes. Please, remember that the IRB committee and Widener University accept no responsibility for liabilities associated with this study. Ultimately, responsibility rests with the investigator.

The approval of this study is in effect for one year from the date of approval and is eligible at that time for renewal. Upon completion of the study, a final written report of the research is to be submitted to the IRB.

The members of the IRB extend their best wishes for your successful completion of this research project. If you have any questions, please call me at [REDACTED]. Thank you.

[REDACTED]
Barbara Patterson, PhD, RN

Cc: Dr. Lois Allen

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o 3800 Vartan Way, P.O. Box 69382, Harrisburg, Pennsylvania 17106-9382



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Institutional Review Board
Department of Medical Affairs
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<http://medaffairs.slhn.org>

August 12, 2004

Ruth Wittmann-Price
[Redacted]

RE: Instrument Development - The Wittmann-Price Decision-Making Scale - SLHN 2004-30

Dear Ms. Wittmann-Price:

The IRB Office has received your application for IRB Approval dated August 10, 2004, for the protocol referenced above from the Research Evaluation Committee.

After reading this research protocol it has been determined that it is not necessary for it to be reviewed by the IRB because it does not fall under FDA regulations and it is exempt per the OHRP regulation §46.101b(2) which states exempt research includes:

Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

You may therefore pursue conducting this study as written.

Please note:

Any changes that you may wish to make to this protocol must be submitted to the IRB Office prior to implementing. The IRB Office will determine if the changes will effect the protocol's exemption status and then respond to you, in writing.

St. Luke's Hospital & Health Network has a Federalwide Assurance (FWA 00003557) from OHRP. The Institutional Review Board is registered with OHRP (IRB 00002757) and is in compliance with 45 CFR 46, 21 CFR 50 and 21 CFR 56. To the extent these Federal regulations are in agreement with the ICH Guidelines, we are also in GCP compliance.

If you have any questions regarding this or other IRB issues please feel free to contact me, [Redacted].

Sincerely,

[Redacted Signature]

Manny Changalis, MS, CIP
Assistant Vice President
Medical & Academic Affairs

Please indicate your acknowledgment of this letter by signing below and returning one copy in the enclosed self-addressed envelope.

[Redacted Signature]

Ruth Wittmann-Price

Aug 16 2004
Date

Big-city medicine. Hometown care.

Dear New Mom,

Congratulations!

I am a nurse working on my doctoral degree and I am studying how women make decisions about health care issues. The statements on the questionnaire are about how you chose to feed your baby. There are also a few questions about your personal background. Your participation in this study is voluntary and your answers will be totally anonymous since you will not put your name on it.

You can do the questionnaire anytime in the next 24 hours. Please place your completed questionnaire in the envelope, seal it and give it to a nurse or place it in the **blue box on the cart by the nursing station.**

Your decision whether or not to participate in this study will not affect the nursing care you or your baby receive in any way. Also, you can decide to stop doing the questionnaire at any time.

The results of this pilot study will help nurses to better understand how women make health care decisions.

Thank you for your participation!

Ruth Wittmann-Price, RN

Widener University Student