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Gender & Society 2003; 17; 462

DOI: 10.1177/0891243203017003010

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**“I’M NOT THE ONE THEY’RE
STICKING THE NEEDLE INTO”
Latino Couples, Fetal Diagnosis, and
the Discourse of Reproductive Rights**

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Despite the growing routinization of prenatal diagnosis, little research has examined men’s roles in this reproductive arena or these technologies’ possibilities for reinforcing or transforming gender roles and relations. The authors analyze male partners’ participation in the amniocentesis decisions of Mexican-origin women at high risk for problems, drawing on interviews with 157 women and 120 of their male partners. The primary aim is to explore whether the normalization of prenatal testing poses a threat to women’s autonomy in this decision arena. The findings challenge critics of new reproductive and genetic technologies who assume that these technologies inherently represent male attempts to control women’s bodies and the processes of reproduction. In contrast, the authors find many couples try to balance their desire to share equally in parenting responsibilities while maintaining the woman’s ultimate control over her body and decisions associated with it.

Keywords: *prenatal testing; reproduction; Latinos; gender politics; men*

The past 20 years have seen much written by feminist scholars and others about the impact of the “new reproductive technologies” on women’s reproductive autonomy. As the array of new biomedical technologies gained public attention in the late 1970s and early 1980s, some warned of the patriarchal incentives to control reproduction embedded in these developments (Arditti, Duelli-Klein, and Minden 1984; Corea 1985; Corea et al. 1987; Rothman 1989). At its extreme, this dystopian radical feminist analysis envisioned women’s roles being limited to their use as wombs for men’s interests. In the past two decades, feminist scholars have taken a much

AUTHORS’ NOTE: *This research was supported in part by the University of California Institute for Mexico and the United States; the University of California, Los Angeles Center for the Study of Women; the National Center for Human Genome Research (1R01 HG001384-01); and the Russell Sage Foundation, as well as a National Institutes of Health postdoctoral National Science Research Award fellowship at the University of California, Los Angeles Mental Retardation Research Center and a Mellon Postdoctoral Fellowship at Brandeis University held by Susan Markens from 1998-99 and 1999-00.*

GENDER & SOCIETY, Vol. 17 No. 3, June 2003 462-481

DOI: 10.1177/0891243203251735

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more nuanced approach to the implications and impact of these new technologies and practices. From ultrasound and amniocentesis to in vitro fertilization and surrogate parenting, empirical analysis has found paradoxical consequences for women—for instance, simultaneously challenging yet reproducing gendered norms about mothers, parenting, and families (Ragoné 1994; Sandelowski 1994).

Yet, to date, there has been little research on what men do, feel, and say with regard to these reproductive arenas that are increasingly defined by biotechnology. Not surprisingly, researchers who have empirically examined men's roles have convincingly challenged simplistic assumptions that increasing use of technology in pregnancy will inevitably lead to or reinforce patriarchal or male control. For instance, research on infertile couples has found that it is women, not men, who are more insistent on the pursuit of various technologies that promise biological parenthood (Ragoné 1994; Sandelowski 1993). Rather than passive victims and pawns, women in these studies are consistently shown to be active agents in determining when and whether to make use of these new reproductive techniques. At the same time, their agency is usually influenced and constrained by the gendered (and largely male-dominated) institutions, roles, and ideologies that shape their everyday lives and the conditions of their existence (Lorber and Bandlamudi 1993).

Other research further challenges radical feminist assumptions that new reproductive technologies are pursued by men and/or reinforce male control over reproduction. For instance, in her research on amniocentesis, Rapp (1999, 147-48) found that many women actively encouraged their male partners to attend prenatal testing and appointments as a way to increase their involvement in the pregnancy. Similarly, in her study of the earliest, most common, and routine form of prenatal diagnosis, ultrasound, Sandelowski (1994) found that while this visioning technique sometimes displaces women's claim to the inherent superiority of unique "embodied" knowledge, at the same time it can promote a more egalitarian model of parenting. In particular, and similar to Rapp's informants, Sandelowski found that the couples who participated in her study viewed ultrasound as a positive opportunity since it helped draw men into sharing the joys (and worries) of parenthood during the prenatal period—something that both sexes said that they wanted.

respectively. The support of each of these institutions is gratefully acknowledged. We also would like to acknowledge Maria Christina Casado, Irma Herrera, Carolina Izquiere, Jesus Montoya, Jeffery McNairy, and Ricardo Rivera who helped with the interviews. We are also grateful to Casado and Rivera for other research assistance they provided and Meghan Howe for assistance in the preparation of the manuscript. We would also like to thank Barbara Browning, David Cunningham, Emily Kolker, Christine Bose, and the anonymous reviewers for Gender & Society for feedback provided and, in particular, Christine Morton for a thoughtful and thorough reading of an earlier draft. Send correspondence to Susan Markens, Department of Sociology, Temple University, Gladfelter Hall 7th floor, 12th Street and Berks Mall, Philadelphia PA 19122; phone: 215-204-6850; fax: 215-204-3352; e-mail: markens@temple.edu.

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Studies such as these bring to the surface an ongoing tension in much feminist writing on reproduction—the simultaneous goals of maintaining (or attaining) women’s reproductive rights and autonomy on one hand and the call for increased male responsibility for and social involvement in reproductive activities on the other (Daniels 1997; Petchesky 1984; Rapp 1999). Similarly, this article is concerned with questions of gender in the context of the increasingly routine use of prenatal diagnostic testing. Our larger study, from which this article emerges, looks at Mexican-origin women and their male partners, examining the decisions they make and the factors that influence them with regard to whether to have an amniocentesis when they have tested positive on a routine blood test that screens for commonly occurring birth anomalies. Here, we are particularly interested in the dynamics that occur between the women and their male partners as they affect and are affected by this decision-making process. That is, we are less concerned with what decisions were ultimately made than with how they were made. In particular, we wish to explore the degree of women’s agency and how it influences the way gender is reproduced, challenged, renegotiated, and/or transformed in the context of prenatal decision making. We examine how the conflicting goals expressed by feminist theorists and scholars play out in the actions, beliefs, and decisions of actual men and women, and the consequences of them.

LITERATURE REVIEW

Researching Mexican-origin couples who are offered amniocentesis may be particularly revealing for those concerned with the interactions of gender, women’s agency, and prenatal testing for several reasons. First, most research on prenatal testing has focused on women (Browner and Press 1995; Kolker and Burke 1994; Markens, Browner, and Press 1999; Press and Browner 1997; Rapp 1999; Rothman 1986). Even when men are included, there is often the assumption—implicit or explicit—that couples act as a unit (e.g., Schover et al. 1998). However, men and women may have differing (and conflicting) attitudes, interests, and concerns when confronted with prenatal diagnosis and its associated issues (Kolker and Burke 1994; Rapp 1999). Furthermore, any understanding of gender cannot solely focus on women, as gender is relational (Lorber 1998; West and Zimmerman 1987).

Second, most research in this field has focused on white, middle-class women (Kolker and Burke 1994; Rothman 1986; Sandelowski 1994). However, as fetal testing becomes an increasingly routine part of prenatal care, it is essential that providers recognize and understand that a diversity of backgrounds, experiences, and concerns of women (and men) may affect their decisions about whether and how to avail themselves of new reproductive technologies such as fetal diagnosis.

Lastly, this population is of particular interest since one of the most pervasive and enduring stereotypes of Mexican-origin families—both in public understandings and in social science research—is its characterization as male dominated (Baca Zinn 1995). However, some have long questioned the actual pervasiveness of

male dominance/female passivity in Latino families (Baca Zinn 1995; Browner and Lewin 1982; Cromwell and Ruiz 1979). And even if a male-dominated pattern was accurate sometime in the past, changing patterns of decision making have been found across generations (Hurtado 1995), with younger couples most likely to be in relationships that they indicate are characterized by joint decision making (Hirsch 1999). Part of this shift is ideological, reflecting changing ideals about family relationships. At the same time, studies show that gender dynamics are affected by socioeconomic conditions and institutional contexts, not just culture. As a result, rather than static and monolithic, many researchers instead have found that a diverse array of gender relations exists within Latino families—from role segregated and patriarchal to egalitarian (Baca Zinn 1980; Vega 1995; Ybarra 1982). Nevertheless, the fact that Mexican immigrant women are significantly more likely than other groups to refuse prenatal screening (Cunningham 1998) has led clinicians (Latino and non-Latino alike) to conclude that this is because men refuse to allow their wives to be tested (C. Garcia, clinical coordinator, University of California, Los Angeles Prenatal Diagnostic Center, Division of Medical Genetics 1995, personal communication; Z. Tatsugawa, genetic counselor, Fetal Assessment Department, Olive View, University of California, Los Angeles Medical Center 1995, personal communication).

The goals of this article, then, are twofold. First, we aim to examine whether the general rise in new reproductive technologies poses a threat to women's reproductive autonomy and decision making in the particular case of prenatal testing. Second, we are interested in the extent to which those decision-making processes reveal gender dynamics among Mexican-origin couples that can be characterized by male dominance/female subservience. In the end, our findings support other research that has challenged the stereotypical myth of male control of decision making in Mexican-origin families in general and reproductive decision making in particular. At the same time, they challenge the radical feminist view that new reproductive technologies will be used to reinforce men's attempts to control women's bodies. As a result, we will argue that these technologies provide a cultural context and institutional setting that may offer opportunities for the renegotiation of gender. At the same time, we show that many of the women in our study retain various degrees of agency over reproductive decision making. In particular, we find many couples actively try to balance their desire for both the man and woman to share equally in parenting responsibilities while at the same time maintaining the woman's ultimate control over her body. Before preceding to our analysis, we first discuss who these men and women are, the context in which they were recruited to participate in the research, and the methods we used.

DATA AND BACKGROUND

This research was carried out within the context of California's state-administered program for prenatal diagnosis. Since 1986, the state of California has

mandated that all pregnant women who enroll in prenatal care prior to the 20th week of gestation be offered maternal serum alpha-fetoprotein (AFP) screening for neural tube defects, Down's syndrome, and other anomalies (California Department of Health Services 1995). Although the test is not mandatory, between 1995 and 1997 approximately 67 percent of babies born in the state were to women who had been screened (California Department of Health Services 1998). California's Expanded AFP-Screening Program is funded like an insurance pool, with a single fee covering the cost of the blood-screening test and, if indicated, genetic counseling, ultrasonography, and amniocentesis at a state-approved prenatal diagnosis center should a woman screen positive. Most fees are paid for by private insurers or by MediCal, California's Medicaid program.

Between 7 percent and 13 percent of women screen positive on AFP, although only 0.1 percent to 0.2 percent of all pregnancies result in the anomalies tested for (Cunningham 1998). Women who screen positive are referred for genetic consultation and further testing at a state-approved prenatal diagnosis center. While typically they are urged by their prenatal care providers to attend this no-cost consultation, they are not obligated to do so. However, it appears that less than 5 percent of women who screen positive turn down the genetic consultation and the offer of additional information about their fetus' health (M. Alvarado, genetic counselor, University of Southern California, Department of Genetics 2000, personal communication; C. Garcia, clinical coordinator, University of California, Los Angeles Prenatal Diagnostic Center, Division of Medical Genetics 1995, personal communication; Z. Tatsugawa, genetic counselor, Fetal Assessment Department, Olive View, University of California, Los Angeles Medical Center 1995, personal communication). They are also encouraged to bring the father of the child with them to the genetic counseling session so that his family history can be directly obtained (Browner and Preloran 1999).

Female study participants were recruited between 1995 and 1997 from seven California state-approved prenatal diagnosis centers where amniocentesis is offered to women at high risk for bearing a child with a birth defect. Our study focused only on women offered amniocentesis because they screened positive on X-AFP. Interviews were conducted after women had decided whether to have amniocentesis, and of those who had agreed to the procedure, a small percentage were still awaiting their results. We conducted semistructured, face-to-face interviews lasting one to several hours with 157 Mexican-origin women and 120 male partners.

Interviews were conducted in the participants' language of choice (69 percent chose to be interviewed in Spanish, 31 percent in English) and usually took place in participants' homes unless they requested another venue. All interviews were tape recorded and transcribed in the language of the interview. For interviews conducted in Spanish, English translations of answers to specific questions examined in this article were made by one of the authors (Preloran). Interviews covered an array of topics about their current pregnancy and conjugal relations, including but not limited to factors considered in the amniocentesis decision, extent of the male partner's

TABLE 1: Characteristics of the Study Population

	<i>Women</i> (<i>n</i> = 157)		<i>Men</i> (<i>n</i> = 120)		<i>Women Omitted</i> (<i>n</i> = 46)	
	<i>Number</i>	<i>Percentage</i>	<i>Number</i>	<i>Percentage</i>	<i>Number</i>	<i>Percentage</i>
Ethnicity						
Mexican American	45	28.7	34	28.3	7	15.2
Mexican immigrant	102	65.0	76	63.3	36	78.3
Other Latino	10	6.4	10	8.3	3	6.5
Education						
Primary or less	41	26.3	31	26.7	14	30.4
Middle school through high school graduation	77	49.4	60	51.7	23	50.0
Some college or more	38	24.4	25	21.6	9	19.6
Household income (\$/year)						
Less than 10,000	50	34.2	34	28.8	15	32.6
10,001 to 20,000	45	29.6	43	36.4	16	34.8
20,001 or more	41	26.8	34	28.8	9	19.6
Don't know	14	9.2	7	5.9	4	8.7

NOTE: The *n*s are less than 157 for women, 120 for men, and 46 for women omitted when data are missing.

participation in the woman's prenatal care in general and in the amniocentesis decision, the extent and nature of the woman's social support, and the role others played in the amniocentesis decision.

There are a few issues about our methods and data that might raise concerns about the validity of key findings from our analysis. First, although, or because, the interview was semistructured, not all informants provided elaborated responses to the open-ended questions posed that are of relevance for this article. In the end, we were able to qualitatively code 71 percent of the data; the rest were omitted. As a result, the sample for analysis is biased toward the English-speaking informants (who were also more likely to be U.S. born): 78 percent of English speakers are included in the qualitative sample, compared to 68 percent of Spanish speakers. While those omitted are not identical on every dimension to the entire sample with regards to sociodemographic characteristics, the variation is small enough to indicate that the smaller sample we use in this article is for the most part fairly representative of the fuller sample (see Table 1).

Second, the original design specified that we interview men and women separately so that each could tell his or her story on his or her own terms. However, 49 percent of the couples requested and were administered joint interviews. We agreed to this request as we discovered during the pilot phase that joint interviews provided rich insight into the dynamics of couples' interactions, as well as providing a

contrast to the individual interviews. We draw on data from both couple and individual interviews in this article. However, a valid question to be raised is whether the fact that a couple was interviewed separately or together influenced the types of responses we received. We did find, for instance, that couples who were interviewed together were more likely than those interviewed separately to be classified by us as exhibiting an "egalitarian" relationship. Yet we are fairly confident that the interview itself did not greatly bias the answers provided by our informants. First, couples chose their interview setting. This suggests that the broad couple dynamics we identify in our analysis affected the type of interview administered, not the other way around. In addition, we found that men who attended the genetic consultation were also more likely to choose to be interviewed jointly with their wives, indicating a consistency of male involvement in different contexts.

Finally, the fact that the research design required both members of the couple to agree to a lengthy interview may have biased the sample in the direction of couples in which the men were more involved with their families and their wives' reproductive health care. However, we employed an array of recruitment strategies to obtain men's participation in our study. These strategies included (1) a standard approach that consisted of contacting one partner in person (usually the woman) and then following up by phone with both partners; (2) corecruitment, whereby we first recruited the woman, she would broach the subject with her male partner, and the researcher would complete the process; (3) a brokering strategy in which after we recruited the woman, and independently of help from us, she would recruit her male partner; and (4) on-the-spot recruiting of both partners at the genetic clinic.

We believe our multiple recruitment techniques provided us with a fairly representative sample of the study population since we found that each distinct strategy was more successful at recruiting men with different degrees of involvement in the amniocentesis decision (see Preloran, Browner, and Leiber 2001 for a further discussion of research strategies). In addition, our sample does not overrepresent involved male partners: During the recruitment phase, we observed that a little less than half of the women attended the consultation alone, and this corresponds to the proportion found among our study population, 55.8 percent of whom attended with their male partners. Lastly, the data analyzed in this article include interviews with 37 women whose partners were not interviewed precisely because they dropped out of the study after the women had been interviewed. Regardless of the precise representativeness of our sample, we argue that the diverse discourses on women's agency that we identify in the following sections still demonstrate the inaccuracy of depicting uniform responses to new reproductive technologies in general, and among Latinos in particular.

ANALYTIC STRATEGY

Since we were interested in the various discourses about and strategies related to women's agency vis-à-vis men's role (or lack thereof) in the reproductive arena, we

initially categorized each couple into one of three analytically distinct patterns of marital decision making—"patriarchal," "role segregated," and "egalitarian"—that have been identified by other researchers studying Latino families (Baca Zinn 1980; Vega 1995; Ybarra 1982). Here, we call these three broad patterns of decision making "couple dynamics." These categorizations were based on two criteria: (1) whether men did or did not attend the genetic consultation and (2) an analysis of the rationales provided by participants when asked to explain his presence or absence. For example, explanations for male presence at the consultation that described men as having control, monitoring, and/or veto over the amniocentesis decision making (e.g., "I want him to approve of the decision") were categorized as patriarchal, while explanations that emphasized equality in the relationship (e.g., "It is both our baby; we share responsibility") were categorized as egalitarian. In contrast, accounts of male absence at the consultation that emphasized a gendered division of labor (e.g., "He had to work" or "She can take care of these matters") were categorized as role segregated. In our sample, 11 percent were categorized as patriarchal, 39 percent as role segregated, and 50 percent as egalitarian. Although both men's and women's responses were used to categorize a particular couple into one of these three broad couple dynamics, an important determination for the categorization was the woman's view of both her and her partner's roles.

It is important to note that these "couple dynamics" are not primarily or solely driven, or characterized by ideological factors. In fact, we found that these broad couple dynamics are associated with socioeconomic variables from immigrant status to income and employment status. For instance, of the Mexican immigrants in our sample, 15.2 percent were categorized as patriarchal, 48.5 percent as role segregated, and 36.4 percent as egalitarian, whereas of the Mexican American women in our sample, 5.3 percent were categorized as patriarchal, 23.7 percent as role segregated, and 71.4 percent as egalitarian. Although there are differences in household income and employment status among the two groups, immigrant status seems to have an independent effect on couple dynamics. More important, given the diversity within each group, it is important to note that among both Mexican immigrant and Mexican American women, those who are employed and are in households with higher income are more likely to be found in egalitarian relationships. These findings are similar to other research on Mexican-origin families that has found that economic and structural variables can affect the degree to which a particular couple is characterized more by male dominance or egalitarianism (Baca Zinn 1980; Hirsch 1999; Ybarra 1982). These findings are a clear reminder that socioeconomic variables can affect how, whether, and to what extent women have agency in any given relationship and the gender dynamics enacted by individual couples. In this article, however, our focus is in mapping out the gendered landscape of amniocentesis decision making and not on their causal mechanisms.

However, we did find that the broad couple dynamics were initially useful for getting at patterned and meaningful differences of agency, control, and behavior. For instance, 40 percent of women we placed in the patriarchal category said their spouses got their way in the amniocentesis decision, as compared to only 2.7

percent and 7.5 percent of women we categorized as being in role-segregated and egalitarian relationships, respectively; at the same time, 70 percent of women classified as role segregated said they got their way in the amniocentesis decision, while nearly 74 percent of women classified as egalitarian said that they shared the decision with their partners.

Yet we also realized that there were great overlap and fluidity between and within categories. That is, placing a range of dynamics and behavior into one of three broadly defined categories obscured the differences within each and the overlap between them and, in turn, diminished the complexity of dynamics exhibited by individual couples. As a result, we returned to the responses given to why men did or did not attend the genetic consultation to analyze and code for more discrete discourses and strategies. Markens created and applied the coding categories in consultation with her coauthors. This stage of the analysis was informed by grounded theory and inductive approaches to social inquiry (Glaser and Strauss 1967). Rather than taking preexisting abstract categories and applying them to the social world, concepts and theories are constructed from the data. Therefore, the specific discourses and strategies we identify are those that emerged as the data were analyzed. In the remainder of this article, therefore, we present a continuum of discourses on women's agency and strategies used during the prenatal period that while corresponding to the categories of role segregated, patriarchal, and egalitarian also serves to break down such categorization. We do this to present the complex and sometimes contradictory way that men and women strategize and rationalize their gendered roles and responsibilities to each other and to their unborn children.

STRATEGIES AND CONTRADICTIONS IN THE GENDERED TERRAIN OF REPRODUCTIVE DECISION MAKING: A CONTINUUM OF DISCOURSES ON WOMEN'S AGENCY

Discourses on a Gendered Division of Labor: From Work Conflict and "Women's Domain" to the Exclusion of Men

Because of the low wages earned by many of our informants, it was not always economically feasible for the male partner to attend the genetic consultation. (More than 60 percent report a household income of \$20,000 or less.) As Roberto and Tea Durengo explained in a joint interview (all names used are pseudonyms):

Roberto: I was working and you know how it is here, when there is work, you can't leave it.

Tea: I didn't say much to him [about coming] because he can't just leave work. If we are left without work, how are we going to live?

Significantly, Jimmy Ortiz explained that although he would have liked to, he did not attend because "I can't keep the [work] place closed." These examples

demonstrate how economic factors can affect the gendered roles and responsibilities a heterosexual couple assumes. In particular, Jimmy Ortiz's inability to pursue his desire to be involved demonstrates that in this context, culture alone does not dictate behavior.

Although we found that the acute economic need of the many low-wage workers in our sample was associated with the inability of men to attend the prenatal care, we also believe that their need to work sometimes masked the fact that many of these couples did not think it was necessary for men to attend because they regard genetic consultation as part of a "women's domain" of authority and decision making. In other words, some of these couples rationalized men's absence by stating that it was expected and/or acceptable for the women to attend the genetic consultation alone. The interplay of these gender dynamics is illustrated by Jesus Posado's explanation of why he was comfortable with the prospect of his wife attending alone: "I had work to do and I could not leave it, and she is the one who takes care of these things, that's why she told me to rest assured." A similar example of how a discourse of "women's domain" is used to explain why some of the men in the study did not actively participate in the amniocentesis decision is seen in the case of Maria Castillo, whose husband drove her to the hospital and then waited for her while she saw a genetic counselor. She was comfortable with this division of responsibilities because "I am the one that knows everything that is related to the children."

Women's agency in these cases, as measured by having responsibility over prenatal care and decisions, is thus shaped by a mutual understanding that this is an arena in which the woman is most qualified to make decisions. The degrees to which women may exert agency in this reproductive arena are revealed by women who reported that their partners did not attend because they did not inform the men or invite them to accompany them. Regardless of the reasons for their male partners' absence at the genetic consultation, since these women attended alone and thus generally made the amniocentesis decisions themselves, they could not be construed as passive agents in this particular reproductive arena. But what about the women whose male partners were actively involved in this decision-making process?

Discourses on "Male Approval": From Paternalism to Women's Insistence of Men's Accountability

For a small minority of couples, women's agency seemed more circumscribed when men became more actively involved. This occurs because "male approval" becomes more salient in the decision-making process. However, what "male approval" may mean for a particular couple's decision can vary. For instance, there were cases in which men actively got their way as did Ricky Aguilera, who succinctly explained, "I convinced her not to [have the amniocentesis]." In fact, Ricky was somewhat paternalistic in his actions, as well as distrustful of the medical system, as he explained his motivation for attending the genetic consultation: "If she went alone, maybe they would convince her to do it." Other instances of men's

paternalism were more indirect and often concerned desires to not be left out of the process and/or to protect their wives. Pedro Ortega, for example, explained his rationale for attending the genetic consultation by expressing uneasiness with his wife attending alone:

I am not too comfortable with the fact that if they are asking her questions, and I rather us both be there so I can answer them right. . . . I don't like to be left in the [dark]. . . . I rather be there myself.

In a similar way, Alberto Benitez mentioned the need to "protect" his wife when he told us his reason for attending: "I don't like her being around there alone in her state [of pregnancy]."

Further variation on the strategy of "male approval" comes from the significant subgroup of women who insisted that their male partners attend the genetic consultation because they wanted their husbands not only to know what options were available but also to explicitly endorse whatever course of action was taken. In other words, these women wanted their husbands involved so that they themselves would not be blamed for any untoward outcome (i.e., miscarriage, pregnancy complications, birth of a child with an anomaly). As Adela Rodriguez explained,

Because if you have to do something, it is better that both be there to talk about it, and see what is best to do and so later they [husbands] don't say, "You did it on your own" and they hold you responsible.

Likewise, Julia Ruiz described why it is important for husbands to be present during the genetic consultation: "So that later he won't say later, 'No . . . well, I didn't tell you' . . . or . . . 'You did it because you wanted to.' . . . So that they don't lay the blame on each other."

On one hand, these women's accounts of wanting and needing "male approval" seem to validate the stereotypical patriarchal model of decision making within Latino families. On the other hand, despite the fact that these women say they are reluctant to pursue a prenatal course of action without their husbands' approval, it does not appear that they accede passively to male partners' expectations. First, several women actively solicited their partners' participation and opinion. Therefore, while these couples might reflect more traditional patterns of couple interaction, with men putatively having ultimate authority, such interaction is by no means characterized by women's passivity. In fact, most men attended the genetic consultation because the women insisted they do so. Typical is Alicia Torre's account:

Interviewer: I would like to know . . . what motivated him to attend?

Alicia: I told him to come.

Interviewer: Did you have to insist?

Alicia: I didn't give him the chance. I told him to come or to come.

Interviewer: (*jokingly*). Then you dragged him by his ear.

Alicia: (*laughing*). Yes. Because I don't want, after, if something should happen, for him to hold it against me. This is why I told him if he didn't come, I wouldn't.

Second, many of the women in this group clearly told their husbands their own views on amniocentesis prior to the consultation—thus, these men attended already “prepped” on the women’s opinions. Therefore, while women maintain that they will abide by their husbands’ decisions about the test, at the same time they actively create a situation in which their male partners are likely to agree with what the woman herself wants. An example of this type of marital dynamic is seen in Laura Vega’s explanation of whose opinion about amniocentesis mattered the most:

We had already . . . before arriving for our [consultation] appointment, I said to him . . . “Okay, they are going to talk to us about this [amniocentesis]. If you think I should do it, then I’ll do it. But my decision is no. But if you want me to do it, I will do it.” ‘Cause sometimes being Latino . . . husbands are like “okay,” that they say, “I support you in everything.” I would imagine, say to myself, “My baby will come . . . [ill]” and that he is going to say to me, “You did not want to do it [amniocentesis].” Then, that is why I told him, “I want you to be aware of what you are going to say. If you want to do it, I will do it for you. But when it comes to me, my decision is no.” I let him listen [to the counselor], and when I said no on my behalf, he also said no.

In the end, although in principle the availability of these technologies could subject women to male control over their fertility, since they seem to ultimately cede the decision to their husbands’ wishes (i.e., wanting “male approval”), many women we interviewed actively used the amniocentesis decision to produce accountability on the part of both partners for reproductive behaviors and outcomes. As the next section shows, further evidence of a continuum of discourses on women’s agency often comes from couples who wanted to attend the consultation together so that they could share in this decision.

Discourses on Egalitarian Relationships: From Supportive Husbands and Shared Parenting to Women’s Bodily Autonomy

Most men in our study accompanied their partners to the genetic consultation, and of these, an egalitarian view of marriage and parenting was often espoused by both partners. We argue that these men’s involvement with and participation in the genetic consultation and decisions about fetal diagnosis indicate that some of the male partners in our study very much want to play an active role in the pregnancy and share in parenting responsibilities. In other words, rather than reflecting the loss of women’s control over one aspect of the reproductive process, many of the women and men we interviewed viewed the men’s participation in the genetic consultation and the decision about amniocentesis as opportunities in which to expand men’s roles in and responsibilities for their yet-to-be-born children. As Dolores Gomez explained, “It’s blood from both of us so we have to see together what is the best for the child.”

Yet, as with the other discourses analyzed, there is a continuum along this “egalitarian” discourse and strategies used by men and women. For instance, for some men their participation in the genetic consultation fits in with their desires to establish a more egalitarian, companionate-like relationship with their partners more generally. In this way, we can see the men’s attendance as a reaffirmation of their relationship with their partners. As Mike Martinez explained, “We go everywhere together; we do everything together.” Likewise, Tony Cruz told us that now that he is older, he has sought to forge a more caring relationship with his wife, and one way he does this is by accompanying her to prenatal appointments:

The first time she was pregnant with my older kid I let her go to the hospital, and now that I grew up more I want to know what she needs or . . . maybe the doctor is going to find out something wrong, and I want to be there so I can support my wife.

Involvement with prenatal care and the amniocentesis decision is thus one way men try to be supportive husbands. As Carlos Vega put it, “I like to be there. That’s all I can do really. I can’t do anything besides to be there for her.”

In other cases, women’s goals for egalitarian relationships were not necessarily shared by their partners. In these cases, although women explicitly desire shared parenting, men’s involvement in the consultation and amniocentesis decision was the result of the women’s efforts to reject role-segregated responsibilities and adopt more egalitarian relationships. A dramatic example of the lengths to which some women went to ensure their husbands’ attendance is Tina Moreno who, like Alicia Torre above, initially refused to attend the consultation without her husband:

Interviewer: Why did your husband attend [the consultation]?

Tina: I think that it is important that both parents hear what the doctors say.

Interviewer: Did you tell him that?

Tina: I told him that if he did not come, I would postpone the appointment.

Interviewer: Postpone?

Tina: Yes, because he was in San Diego working with his brother and he didn’t want to come just for an appointment.

Interviewer: Why?

Tina: Because he said I could explain [what happened] to him by phone.

Interviewer: And what did you think?

Tina: I thought that’s not right because the baby is not only mine but his [too]. And they [doctors] invited us together. I was not going to go alone, as if I did not have a husband.

Interviewer: And how did you convince him?

Tina: I told him that if he didn’t come, I would postpone the appointment, and if something happened to the baby, it would be his fault . . . and I told him that *we* have to care for the baby even before it is born. Don’t you think so? (Emphasis added.)

In cases like this, women’s insistence on men’s involvement reveals that some women did not consider their partners’ need to work as more important than joint responsibility for prenatal decisions.

Yet, despite some men's resistance, the same notion of shared parenting was expressed quite clearly by many of our male informants. For instance, Marco Rivera told us, "We went [together] to decide together because it's our baby." Likewise, Luis Lopez explained, "It's both our blood and both parents should be there." The many men who attended the genetic consultation often said they became involved because they wanted to assume a role of shared parenting, and part of that role entailed joint responsibility for a decision about amniocentesis. In fact, some men's desires to share parenting responsibility reflected their active involvement throughout the entire prenatal period. For example, Victor Cedeno explained,

I've been going with her [to her prenatal appointments] since we found out that she was pregnant and I thought [that] . . . this is my baby too. I want to have a part in it too. I want to know everything about if it is good or bad things. I want to go through it with her too, you know.

It is important to emphasize, however, that these men are by no means appropriating the reproductive arena. Rather, women take advantage of the genetic consultation and the need to decide about fetal diagnosis to incorporate their partners in the pregnancy experience. In these cases, women want, appreciate, and encourage their partners' involvement as much as the men do. Despite the fact that it was the women who were pregnant, several of them saw prenatal care and its associated technologies as an avenue through which they could reinforce shared parenting prior to the birth. For instance, as Rita Fernandez clearly states below, her partner is accountable even during this prenatal period. At the same time, her reasons for wanting him to participate in the decision about fetal diagnosis also show that some women view it as a welcome means through which to greatly involve their partners:

It is his baby too. He was around the scene of the crime when this happened. So he has to take an amount of responsibility, not necessarily as my husband, as the father of the baby. I have a very big role in making the baby right now and he doesn't feel the pain I go through and the changes that are in my head and the things that I think about. So the least he can do is be there to support me and also his unborn child. It makes me feel that he's a little more involved. Because I don't want him to feel excluded. . . . I can't just go take the baby out and say okay, you hold it this week. I want to include him as much as possible and I feel that going to the doctor and keeping him informed about everything that is going on is part of him being involved.

These compelling examples of the desire for shared parenting among both men and women clearly refute a simplistic patriarchal model of Mexican-origin families. Furthermore, while the men's inclusion in prenatal decision making may be viewed as an infringement on women's reproductive autonomy, the accounts from our male and female informants challenge this interpretation. First, men's involvement was encouraged and appreciated by virtually all of our female study participants in this egalitarian group. Second, while these couples pursued a model of

shared parenting with regard to men's attendance at the prenatal genetic consultation session, ultimately most men and women ceded the decision of whether to have an amniocentesis to her.

This raises an interesting paradox. Given the fact that many of our participants expressed an egalitarian approach to parenting and marriage, why did so many also report that it was the women who had the ultimate say over whether to undergo amniocentesis? We found that many study participants drew on and appropriated contemporary discourses of reproductive rights and bodily autonomy to account for who had the most control in the decision-making process. What we saw was that men's opinions were often solicited, but in the end women had more say in the matter. In this way, women's agency is often maintained despite the goals of shared parenting.

The dominance of a patient autonomy/reproductive rights framework in ceding decision making to the woman is first illustrated in a case involving a young unmarried couple who did not agree about amniocentesis. In discussing how his girlfriend had the amniocentesis over his objections, Cesar Guzman acknowledged that legally and medically his opinion did not and could not influence what happened: "I told her it was up to her. I couldn't say no to the doctor. The doctor would have believed her more than me." Thus, despite his disagreement with his girlfriend's desire to have an amniocentesis, when asked whose opinion mattered the most Cesar regretfully acknowledged the reproductive autonomy the institutional setting confers on to pregnant women: "It's up to the woman I guess."

This example clearly reveals the role of institutions in shaping behavior and shows that monolithic, static, and cultural explanations for Latino reproductive behavior and decision making are inaccurate and simplistic (Browner 2000). For instance, while men may be encouraged to attend the genetic consultation, the only signature required on consent forms, for both the initial X-AFP screening and the subsequent amniocentesis, is the woman's. In this way, medical autonomy in decision making is built into American medicine more generally, as well as the California state-sponsored X-AFP screening program in particular (Browner and Press 1996).

Although some men reluctantly ceded a degree of reproductive and medical autonomy to women, it seemed that most men and women in "egalitarian" couples, as well as many "role-segregated" couples, shared a similar orientation toward bodily rights: The amniocentesis decision was the woman's to make in that it was both claimed by the woman and ceded by the man. Yet women's agency was often masked because many couples' first response to the direct question of "who made the amniocentesis decision" was that the decision was equally shared. For instance, while nearly 74 percent of women classified in egalitarian relationships said both got their way in the amniocentesis decisions, when further probed both men and women claimed that the women in these relationships had the final word. These dynamics were often obscured, even by the couples themselves, because so many of the couples reported that they agreed on the decision that had been made. For

instance, Christina and Hector Hernandez had agreed on having an amniocentesis during a previous pregnancy and agreed to refuse the offer during the current pregnancy. Yet, on reflection, Hector recognized that both times their agreement obfuscated the fact that he would not insist that she abide by his wishes:

Interviewer: Who got their way?

Hector: I think it was both.

Christina: Yes.

Hector: I think you could say it was a little bit more hers. . . . I am not going to force her to, but I think it was something that we both agreed in not having and the other we agreed to wanting it.

What is interesting about such accounts was the framework that both partners used to explain why it was her decision. Many study participants drew on contemporary notions of reproductive rights and bodily autonomy. That is, both genders appropriated the ideology that women should have medically autonomous decision making about procedures that affected their own bodies. That is why many couples saw no contradiction in both drawing on a rhetoric of shared parenting to justify the men's active involvement during the prenatal period yet agreeing that final authority over the amniocentesis decision was the woman's.

Therefore, a common account of the amniocentesis decision process was that women consult their husbands about their views on the advisability of amniocentesis, but they will not necessarily do what they say. As Ramona Suarez explained,

I knew all along that it was my decision because it's . . . the baby is inside me and I do feel that ultimately it [the decision] is [mine]. . . . I know I asked him how he felt, but not necessarily what he wanted me to do.

Likewise, Teresa Garcia, who attended the consultation with her partner, directly acknowledged that it was this corporeal component that affected why the woman's opinion mattered the most in this arena:

Interviewer: How did you decide, did he try to convince you?

Teresa: No, I think we made our decision in like two minutes and basically it was my decision to make because I was the one who was going to get stabbed about 20 times with a 20-inch needle.

Juan: About 17 millimeters.

Teresa: It felt like 20 inches. You know, it is my body, so like I said, Juan trusts me with like any decision I make. Well not any decision but in this area about my body and the health of the baby he trusts me. As soon as I put him at ease that I wanted to do it I think he was like, okay, he had no doubt.

Although this reference to women's reproductive rights was most often revealed among egalitarian couples, similar views were expressed by women in role-segregated couples. In fact, assertions of bodily autonomy were often the rationale for

why male partners were not invited or needed at the genetic consultation. For instance, when asked if it would have helped if she had made the decision with her boyfriend who had not attended, Diana Soja responded, "No because . . . I make my own decision on what is going to happen to my body."

Yet it is important to emphasize that it is not only women who claimed reproductive autonomy. Men, particularly those in egalitarian relationships, were also clear about the fact that their partners had, as Andrew Melendez put it, "more of a little say so" when it came to a decision about amniocentesis:

Interviewer: Whose opinion counted the most?

Olivia: Well we both agreed. But . . . in the end it is my opinion.

Andrew: To me it is her body so she has more of a little say so than I do in that decision.

Interviewer: So for you it was her decision that counted most?

Andrew: Huh yeah. . . . I mean that it was my opinion that counted to me, but I wasn't going to go against her wishes because she is the one having them, you know. It's her body. Whatever she wants to do.

A final example that reveals this dynamic is Jennifer and Manuel Baca. On one hand, Jennifer clearly indicates that the decision is hers and no one else's. At the same time, although Manuel acknowledges their joint responsibilities as parents to their unborn child, he clearly separates this from his wife's rights to bodily autonomy.

Interviewer: Whose opinion mattered the most?

Jennifer: I adore my husband but it's my decision not [his], my mother's, my son's, or my mother-in-law's, no.

Manuel: It's her body, the child is both of ours, but they do the test on her; therefore the decision is hers.

Paradoxically, then, while many Mexican American couples find that an offer of amniocentesis can equalize parenting relations and responsibilities, the result is not necessarily more control by men over their wives' reproductive experience, or even true gender egalitarianism. Instead, by drawing on a rhetoric of reproductive/bodily autonomy, women tend to remain the more active agents. Nevertheless, there is an inherent contradiction between the discourses of "it's our baby" and "it's her/my body," a contradiction mirrored in the tensions of feminists' twin goals of increasing men's parental involvement while maintaining women's reproductive control. The narratives analyzed above clearly reveal the complexity of these negotiation processes as they are reflected in amniocentesis decision making. The process and rationales seen in these couples' amniocentesis decisions—separating responsibility for the fetus/child from women's bodily autonomy—point to ways that these seemingly contradictory feminist goals can be successfully navigated and achieved.

DISCUSSION

Our analysis has implications for understanding the gendered nature of family decision making, as well as medicalization processes and women's agency. First, this study reaffirms other research that has challenged the stereotypical myth of the *machista* patriarchal man with regard to decision making in Mexican-origin families. The prevalence of egalitarian and shared-parenting orientations expressed by many of our study participants, as well as men's and women's assertions of women's bodily autonomy, challenges the stereotype of male dominance and female passivity in reproductive decision making. This suggests that popular perceptions of machismo, as well as female subservience, are often overstated or are complete distortions.

In addition, we extend our understanding of men's roles in reproductive decision making: We find that women are active agents in the medicalization processes and that they are the ones who use new reproductive and genetic technologies to increase men's involvement. Our study empirically illuminates the tension between women's autonomy and increased male responsibility that is found theoretically in feminists' writings on reproduction. Thus, we document how these women and men simultaneously reproduce and challenge norms about gender and parenting.

At the same time, the larger gendered world of roles and institutions almost certainly shapes how and which individual decisions are made and strategies are pursued. Thus, even for those attempting to share parenting via decisions about amniocentesis, the women in these couples were probably also affected by the reality of the "second shift" and their continuing responsibility for childrearing and domestic work (Hochschild 1989; Press and Townsley 1998), as well as gender segregation in the labor force and the concomitant persistent pay gap between men and women (National Committee on Pay Equity 2001).

In addition, our findings clearly suggest the effect of socioeconomic resources on the degree to which individual women can push for and achieve shared parenting with their male partners. As we mentioned earlier, women who reported higher household incomes, were employed, and were born in the United States were more likely to be in the couple dynamic that we initially characterized as egalitarian. In contrast, the most common reason both women and men gave for the men's failure to attend the genetic consultation was a conflict with work responsibility (a finding similar to Heymann 2000). Thus, while our small qualitative sample does indicate the importance of immigrant status and economic variables on couple dynamics, further research with larger samples is still needed to specify these relationships.

In the end, by identifying the diverse patterns of couple dynamics and the range of women's agency exerted in the context of amniocentesis decision making, we reveal some of the ways in which gender can be renegotiated. Prenatal testing opens up a space during pregnancy for shared decision making and egalitarian parenting—that may or may not have long-term consequences for the gendered

dynamics of particular relationships. We see women as agents, but their “choices” about amniocentesis are constrained. To paraphrase Marx, these women make their own decisions, but they do not choose outside the gendered context of their lives, or under circumstances they have chosen. And yet the reproductive “choices” made by the women in our amniocentesis study were, for the most part, their own.

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