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The Bad Mother: Stigma, Abortion and Surrogacy

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Introduction

Surrogacy and abortion represent two facets of procreative liberty, the right to reproduce and the right to avoid reproducing. Research on stigma associated with abortion and surrogacy illuminates how these very different experiences carry similar stigmatic harm. Why do certain decisions about reproduction engender social support, other decisions social disapproval? Restrictions on surrogacy and abortion derive from a common legal paradigm — state regulation on the pregnant body — that is rooted in traditional gender roles. Not all laws restricting abortion and surrogacy evince gender stereotyping. Abortion and surrogacy pose complex moral and social dilemmas. But research of stigma associated with abortion and surrogacy suggests that gender stereotypes play a role in the creation of stigma.

This stigma reflects complex cultural disagreements about the meaning of maternity. The debate is framed by medical advancements that have transformed our understanding of reproduction. Despite the fact that modern birth control has been available for over 50 years, the separation of sexual intercourse from reproduction continues to generate social controversy.[1] Advances in assisted reproductive technologies and reproductive medicine have altered the social construct of motherhood, fracturing the cultural understanding that motherhood is biological and inevitable.[2] Prior to these advances, pregnancy was the expected outcome of sexual intercourse and motherhood was understood to begin with pregnancy.

Surrogacy and abortion disrupt traditional expectations regarding pregnancy by separating gestation from maternity. A pregnant woman who bears a child for another or who chooses abortion embodies the archetype of the bad mother by "abandoning" her child.[3] She transgresses the social understanding that "respect for human life finds an ultimate expression in the bond of love the mother has for her child."[4] Stigma attached to these reproductive decisions reflects a legacy of gendered roles and disapproval of women who fail to conform to social expectations of motherhood.

This article examines how stigma attached to abortion and surrogacy reveals similar patterns of gender stereotyping. It argues that evidence of stigma is relevant to determining whether laws regulating abortion or surrogacy are based on impermissible stereotyping. Evidence of stigma is probative of two significant issues, whether gender stereotypes influenced legislative purpose, and the degree of harm imposed by a regulation, for stigma may adversely impact reproductive decisions.

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I. Good Mother/Bad Mother

Maternity is widely understood as biological.[5] Society deems the attachment between a woman and the fetus she is carrying as innate and genetically ordained, despite evidence to the contrary.[6] Conception is assumed to begin a process that inevitably leads to gestation and nurturance; the social identity of women has been shaped by the expectation that women are "natural" nurturers.[7] To the extent both abortion and surrogacy suggest that maternal bonds are a function of choice, they are at odds with this assumption.[8] Surrogacy and abortion challenge the socially constructed understanding of maternity, separating conception and pregnancy from parenting, and disrupting the unity of reproductive work.[9] Social changes that challenge cultural norms are likely to be met with resistance and dissonance; stigma is one manifestation of the social dissonance surrounding gender roles.[10]

Social perceptions of maternity are shaped in part by pronatalist values, which are foundational to social organization and religion.[11] The state historically has asserted its interest in assuring healthy offspring; women bear the primary responsibility for raising and socializing each new generation of citizens.[12] Thus, private decisions about reproduction are drawn into the public arena. The social value placed on fertility is pervasive across gender, age, race, religious, and class distinctions.[13] These norms are exceedingly resistant to change.[14]

The controversies over abortion and surrogacy evoke two archetypes — the good mother and the bad mother. Popular culture frames these archetypes in various ways, lionizing the "supermom" and demonizing women who delay or reject childbearing for personal or professional reasons.[15] The good mother embraces her maternal role, accepting the social link between conception, gestation, and maternal bonds. She is self-sacrificing, putting the demands of her maternal role before other personal choices. The bad mother, by contrast, acts in ways that reject the inevitability of maternal bonds.[16] Thus a woman who terminates a pregnancy or becomes a surrogate is by definition a bad mother. The bad mother manifests two similar moral failings common to perceptions of abortion and surrogacy. First, by rejecting her maternal role she abandons her child. Second, a bad mother is one who puts personal concerns before motherhood.[17]

Social movements opposing surrogacy and abortion share overlapping identities and narratives. Surrogacy emerged as a contentious issue in conjunction with the media frenzy surrounding the Baby M case in 1986. The visibility of the "pro-life" movement increased during this same period.[18] The coalition of social conservatives and religious groups that opposed surrogacy also has played a significant role in opposing legal abortion.[19] Unlike abortion, controversy over surrogacy has been episodic, but moral disgust has been a prevalent theme invoked by opponents of both practices.[20]

Public discourse about abortion and surrogacy tracks the extent to which maternal identity issues dominate. Negative political framings of abortion and surrogacy rely on the bad mother archetype, drawing on embedded social taboos, such as identifying abortion with murder. Pro-life social movements have effectively connected abortion to broader social themes of family values, emphasizing the significance of traditional maternal roles to family stability.[21] Surrogacy is defined as baby selling; the surrogate is portrayed as a breeder for hire.[22] The moral disgust frequently attached to surrogacy extends beyond objections concerned with the potential for exploitation of economic disparities.[23] Surrogacy and abortion engender dissonance that society may resolve by labeling women who select abortion or surrogacy within the familiar construct of the bad mother. If we examine the effects of this social censure on women who choose abortion or decide to become a surrogate, the

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links emerge between social disapproval, stigma, and gender stereotyping.

II. Stigma and Stereotyping

Influential sociologist Erving Goffman describes stigma as an "attribute that is deeply discrediting," that reduces the bearer "from a whole and usual person to a tainted, discounted one."[24] Most researchers agree that stigma (1) concerns an attribute that marks an individual as different or "other" and (2) is socially constructed.[25] Stigma is particularly associated with identity norms and deviations from group identity may give rise to stigma.[26]

Stigma may be experienced in several ways. Internalized stigma occurs when the individual accepts and incorporates a negative cultural judgment as part of her identity.[27] Stigma also may be "felt" when an individual perceives negative attitudes from others.[28] Finally, "enacted" stigma occurs when the individual encounters prejudice or discrimination.[29] Individuals who experience stigma may suffer psychological harm or chronic physiological stress responses.[30]

Not all forms of differentiation generate stigma, nor do negative public attitudes alone create stigma. Researchers Bruce Link and Jo Phelan theorize that stigma occurs when a number of interrelated components converge; the dominant culture acts to label and stereotype undesirable behavior or characteristics and these actions lead to isolation and status loss or discrimination for those identified as "other."[31]

Social inequalities contribute to the creation and experience of stigma.[32] Economic disparities particularly influence public perceptions of abortion and surrogacy. Restrictions on access to abortion are especially burdensome to low-income women who rely on abortion clinics.[33] They are apt to encounter challenges in arranging time off from work and family and are likely to face harassment from clinic protests.[34] Economic disparities play a large role in perceptions of surrogacy as well.[35] The Baby M case embodied the stereotypes associated with surrogacy – the wealthy, educated, white intended parents contracting with the socially and economically disadvantaged surrogate. Negative public attitudes toward surrogacy are shaped in part by the view that surrogates are desperately poor women forced to sell their bodies or their babies, despite the fact that surrogates in the United States typically are working-class women.[36]

Link and Phelan argue that certain differentiations carry substantial social power, particularly distinctions based on race and gender.[37] Stereotyping based on these traits may be automatic and preconscious.[38] Abortion and surrogacy, experienced only by women, are particularly susceptible to gender-based stigma.[39] "Bad mother" stigma is constructed through a multifaceted framework of messages and experiences that include the beliefs of the individual and her interactions with friends, family, the community, and society.[40] It labels women who seek abortions as "promiscuous, sinful, selfish, dirty, irresponsible, heartless or murderous."[41] Likewise, the surrogate is deemed a coldhearted baby-seller or a fool.[42] Women who experience stigma learn these negative stereotypes and frequently internalize poor self-judgments.[43]

When reproductive decisions are stigmatized, both the women who make these decisions and the procedures become marginalized. Marginalization leads to further stigma and isolation that may encourage additional legal restrictions; stigma thus becomes normalized.[44] If we examine public attitudes toward surrogacy and abortion and the experiences of women who become surrogates or terminate a pregnancy, common patterns emerge. First, public attitudes toward these decisions evince similar demarcations of moral approval and

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III. Surrogacy and Stigma

Discourse surrounding surrogacy often reflects the good mother/bad mother binary. On one hand, surrogacy is extolled as a reproductive decision that allows an otherwise infertile couple to have a child with a genetic connection to one or both of the intended parents.[45] In contrast, surrogacy is decried as exploitation of a woman's body, as classist and sexist, and the marketing of babies.[46] Surrogacy divides feminists; some argue surrogacy recognizes a woman's moral agency, others condemn surrogacy for reinforcing the association of woman with womb.[47] These widely divergent analyses address a common normative question – how to distinguish between the social and biological attributes of maternity. This question informs the analysis of surrogacy and stigma.

Surrogacy may involve one of two types of biological arrangements. Traditional surrogacy relies on artificial insemination of the surrogate's eggs with the intended father's sperm. Thus, the surrogate is the genetic mother.[48] The second form of surrogacy, gestational surrogacy, involves the implantation in the surrogate of an embryo that contains the sperm and egg of the intended parents, or their donors. The gestational surrogate carries no genetic connection to the baby.[49] Gestational surrogacy is now the preferred and dominant approach, with 95% of surrogacy contracts based on IVF.[50] Its dominance is due, at least in part, to the perceived moral differences between traditional and gestational surrogacy, discussed, below.[51] Strong preferences of parents to have a child with a genetic connection to one or both of the parents provide some insight into why a woman who terminates a pregnancy may be stigmatized.[52] Similarly, research suggests that the significance attached to genetic relatedness explains why genetic surrogates are perceived less favorably than gestational surrogates.[53]

An early and influential assessment of surrogacy, the British Warnock Report published in 1984, offers harsh moral criticism of surrogacy: "To deliberately become pregnant with the intention of giving up the child distorts the relationship between mother and child."[54] The report explains that an arrangement where the woman who deliberately becomes pregnant with the intention of giving up the child at birth is the "wrong way" to approach pregnancy.[55] It also describes significant social objections to surrogacy for undermining the value of the marital relationship. The Warnock Report expresses no doubt that courts faced with surrogacy disputes should find the arrangement void as against public policy.[56] It assumes that the best interests of the child lie with the surrogate and recommends that the woman who gives birth be considered the legal mother for all purposes, even in a gestational surrogacy arrangement.[57] The report concludes that surrogacy for "convenience" was "morally unacceptable," and questionable in "compelling" medical circumstances because it is exploitive to treat other humans as a means to one's own ends.[58] Britain embraced this moral critique by banning commercial surrogacy arrangements.[59]

The Baby M case had a significant impact on the public perception of surrogacy in America.[60] The controversy surrounding Baby M, which involved a traditional surrogacy agreement, produced a negative framing of surrogacy, depicting it as baby selling and exploitive of low-income women. The New Jersey Supreme Court's repeated descriptions of surrogacy as "baby-bartering" or "baby-buying" and "selling" became part of the public discourse about surrogacy.[61] The case led to a flurry of legislative action throughout the states seeking to ban surrogacy as against public policy.[62] The moral revulsion that widely greeted Baby M may, in part, be a reflection of the discomfort associated with new reproductive technologies. But the tenor of the debate, particularly the focus on the moral assessment of the women involved, suggests the case challenged traditional norms of maternity. The narrative generated by Baby M insisted that motherhood was the inescapable consequence of pregnancy. Surrogates could not be expected to negate this biological identity; they were destined to regret their decision and thus were incapable of informed consent.

Public opposition to surrogacy coalesced after the Baby M case.[63] Decades later, surrogacy is still considered the least acceptable way to have a child.[64] Only a minority of states directly regulates surrogacy; most jurisdictions resolve disputes through contract and family law principles, leaving the decision to enter into a surrogacy arrangement a risky legal undertaking.[65]

One recent study of British women's attitudes suggests that stigma is widely associated with surrogacy.[66] This data is consistent with results in the United States and Canada.[67] Surrogates widely report experience of stigma.[68] Stigma may impact personal relationships: some surrogates report significant lack of social support from partners and families, particularly at two critical and symbolic stages of the pregnancy: early in the pregnancy when the success of the pregnancy is established and post-delivery when the surrogate relinquishes the baby.[69] A 2005 survey of research on the psychological and social aspects of surrogacy in the United States and Great Britain reported that while husbands and partners were generally supportive,

more than half of the surrogates surveyed experienced increased conflict in their extended family relationships as a result of their decision to become a surrogate; 40% reported loss of a significant relationship.[70]

Religion appears to be a relevant factor, in surrogacy as with abortion, with those who identify as religious less inclined to find these practices acceptable.[71] The Catholic Church opposes reproductive technologies, including surrogacy.[72] A brief filed in the Baby M case by the New Jersey Catholic Conference, describes surrogacy this way: "In surrogacy, a child is conceived precisely in order to be abandoned to others…"[73] This statement gets to the heart of the moral disapproval of surrogacy. Not all actions that result in relinquishing a child are perceived as objectionable. Adoption tends to be perceived as a morally appropriate response to untenable circumstances, presumably with the best interest of the child the foremost concern. In that sense the abandonment is "excused." Surrogacy by contrast is labeled offensive because it involves the intention both to conceive and abandon. This purposeful bypass, not of conception or gestation, but of motherhood, is at odds with social norms linking gestation to maternal bonding.

Surrogates and surrogacy programs take measures to reduce stigma, characterizing surrogacy in terms that are consistent with social expectations of motherhood and reproduction. Financial remuneration is de-emphasized; compensation in fact may be intentionally low.[74] Few surrogates, particularly gestational surrogates, regret their decisions; they typically view their role as participating in the "gift of life."[75] The casting of surrogacy as the gift of a child rather than a business transaction brings the practice more in line with traditional views of self-sacrificing mothers. This emphasis on altruism over remuneration has been critical to legislative recognition of noncommercial surrogacy.[76] The "gift of life" cannot be sold, but the law may recognize a woman's selfless desire to help a childless couple.[77] Altruism is deemed incompatible with remuneration; this dichotomy allows commercial surrogacy to be condemned as the prostitution of maternity.[78] The moral disgust associated with commercial surrogacy correlates to social disapproval of abortion for economic reasons; both create dissonance with the model of altruistic maternity. Popular culture reinforces stereotypes of commercial surrogates as greedy, uneducated, and dishonest.[79]

The shift to gestational surrogacy has engendered a change in the social discourse, and, to some extent, the stigma associated with surrogacy. Surrogates are now described as "gestational carriers" rather than mothers.[80] The altered social framing has generated greater public acceptance of gestational surrogacy.[81] This development suggests that the constructed meaning of maternity is grounded in the correlation between genetic and maternal identity. The pregnancy per se is not the source of the maternal obligation; the stigma of abandonment attaches with genetic relation. The absence of genetic relationship allows gestational surrogacy to more easily be characterized as a medical response to infertility.

The divergent framing of traditional surrogacy and gestational surrogacy expresses the relative moral comfort culture attaches to one practice and not the other. Gestational surrogacy does not threaten the genetic-based theory of maternity to the same extent as traditional surrogacy; the traditional surrogate and the woman who chooses abortion are stigmatized for challenging the inevitability of genetic attachment.[82] Despite this distinction, gestational surrogacy is not free of gendered stigma; common law presumed the birth mother was the legal mother, and the maxim *mater est quam gestation demonstrate* (by gestation the mother is demonstrated) remains a common legal basis for establishing maternity.[83] Further, the biochemical and hormonal relationship that nurtures the fetus during pregnancy may satisfy social and legal definitions of maternity.[84]

IV. Abortion and Stigma

If the bad mother is defined primarily as a woman who abandons her genetic relation, the woman who terminates a pregnancy is likely to encounter stigma. Unlike the planned pregnancies of surrogacy, most abortions occur as the result of unintended pregnancies.[85] While the intent to conceive may not be present, the decision to terminate a pregnancy may be perceived as the ultimate abandonment of the life in being, a rejection of maternity and of the "essential nature" of woman.[86] Negative social framing of abortion frequently reflects strong moral disapproval.[87] This disapproval, influenced in part by the lack of public awareness about the commonness of abortion, highly polarized political discourse, and public ambivalence about acceptable circumstances for abortion, can contribute to stigma and the experience of isolation and social denigration associated with stigma.[88]

Abortion stigma has deep historical roots in negative social attitudes toward women who decline maternity; abortion often was associated with out-of-wedlock sex, promiscuity, and prostitution.[89] Women who terminated pregnancies typically were depicted as impoverished and desperate.[90] By the late 19th century, abortion became part of a larger cultural debate; concerns that white, middle class women were rejecting their "roles" as child bearers and raisers led to a nationwide movement to criminalize abortion.[91]

Women who supported abortion were berated as frivolous and self-indulgent.[92] Pre-*Roe*, the procedure was identified with the unsafe reality of "back alley" abortions.[93] The post-*Roe* political backlash against abortion demonstrates how stigma can be used to discredit legally protected conduct.[94]

Public support of abortion has remained generally consistent since *Roe v. Wade* was decided in 1973.[95] A majority of Americans favor the legality of abortion, although that majority has decreased in recent years.[96] Approval deviates sharply however when the reasons for the abortion are considered.[97] Abortion is widely accepted as a response to significant health risks, rape, or serious fetal anomalies but acceptance drops below 50% when abortion is chosen for reasons of social, economic or personal hardship.[98] Public opposition to abortion in the absence of rape or medical risk has increased since 1992 when the Supreme Court opened the door to greater regulation of abortion in *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[99] and rekindled a high profile national debate.[100]

These demarcations in approval are consistent with the good mother/bad mother binary. Abortion is more acceptable to many when the woman is perceived as a victim of circumstances beyond her control, whether the acts of another or medical happenstance. The woman who decides to terminate her pregnancy for personal or economic reasons is less deserving of respect because she is rejecting motherhood for selfish reasons. The woman who chooses abortion in order to better provide for children she already has receives little sympathy.

Abortion stigma was common during the pre-*Roe* era of criminalized abortion.[101] Current data showing high rates of underreporting of abortions, active concealment, and fear of social rejection suggests that legalization has not eliminated the stigma.[102] Multiple studies conclude most women experience abortion as a stigmatizing event.[103] Socio-economic factors play a significant role in mediating abortion stigma including racial and ethnic identity, economic status, geography, and religion.[104] As with surrogacy, stigma is most commonly experienced as external disapproval.[105]

A recent study of women who terminated pregnancies concludes that 67% perceived or experienced disapproval from others, including friends and family.[106] Abortion stigma derives from social disapproval as well; in one study women identified sources of stigma from how society "discusses abortion" or "talks about women who have had an abortion."[107] Negative female stereotypes influence a woman's experience of stigma; respondents expected others to perceive them as immoral or sinful, a "slut" or a bad mother.[108] As one woman explains, "[Y]ou're supposed to feel totally ashamed…and you're supposed to feel like you murdered someone and you're supposed to punish yourself."[109]

Abortion stigma is considered "concealable"; the stigmatizing trait is visible to others only upon disclosure.[110] A woman who terminates a pregnancy must decide whether and how to disclose her experience [111] Secretive behavior, such as a desire to conceal the abortion or allow only selective disclosure, is a common response to real or perceived stigma.[112] Stigma can contribute to delays in scheduling the procedure, increasing the risk of medical or legal complications.[113] Stigma, and the desire to maintain secrecy, may also influence women to choose unsafe procedures, including self-induction or the use of untrained personnel.[114]

Abortion stigma may be experienced as episodic or intermittent, often arising during events or experience where there is an option for disclosure.[115] The psychological consequences of abortion stigma vary, depending on the relationship of the stigma to self-identity.[116] Stigma and concealment are positively associated with psychological distress following first-trimester abortion in the United States.[117] Psychological repercussions of stigma may be "profound."[118] Social psychologist Brenda Major writes, "Women who come to internalize stigma associated with abortion (e.g., who see themselves as tainted, flawed, or morally deficient) are likely to be particularly vulnerable to later psychological distress."[119]

Abortion stigma is normalized through a "prevalence paradox.[120] Most women conceal their abortions, fearing stigma and lack of support.[121] Concealment creates a false perception that abortion is uncommon.[122] This misperception transforms into a social norm that labels abortion, and the women who have them, as deviant, furthering a cycle of secrecy and stigma.[123] Secrecy carries multiple risks: women who conceal abortions report insomnia, panic attacks, and anxiety.[124]

Like regulation of surrogacy, laws restricting abortion reflect a profound social disquiet about the separation of sex from procreation and women from motherhood. The woman who terminates a pregnancy is stigmatized for the ultimate, irrevocable "abandonment" of the child.

The surrogate or the woman who has an abortion may experience stigma differently depending on her personal circumstances and on the type of stigma she encounters. Because abortion is a concealable act, the stigma experienced is more likely to be felt or perceived than enacted. The surrogate, who cannot conceal the fact of pregnancy, is thus more likely to face enacted stigma. She may choose to manage stigma by

concealing the circumstances of her pregnancy from all but family and close friends. Psychological stress relating to disclosure and concealment thus may be present with both abortion and surrogacy.

V. Gender Stereotypes in the Regulation of Abortion and Surrogacy

The socio-legal arguments against abortion and surrogacy bear notable similarities. Decisions that challenge the social construction of maternity are considered unreliable or immoral, in large part because of traditional stereotypes that deny women moral agency. Laws regulating abortion and surrogacy often reinforce these stigmatizing stereotypes

A. Distrust of Judgment

Laws that question the moral agency of women perpetuate stereotypes that women lack the capacity for rational decision-making.[125] The widely held perception that women frequently decide to terminate a pregnancy or use a surrogate for purposes of reproductive "convenience" is one visible example of how culture may devalue women's judgment.[126]

Informed consent, a capacity credited to adults from common law, is suspect when a woman decides to become a surrogate or terminate a pregnancy.[127] The debate over whether informed consent is possible underlies the legal and ethical treatment of abortion and surrogacy. The assumption in both circumstances is that a rational woman would not voluntarily disrupt the connection between pregnancy and maternity. As the New Jersey Supreme Court concluded regarding informed consent by the surrogate in the Baby M case, "[Q]uite clearly any decision prior to the baby's birth is, in the most important sense, uninformed."[128] The court assumes the inevitability of the maternal bond, presuming that the uniqueness of gestation results in a type of diminished capacity to make decisions concerning the pregnancy. Baby M may not fully reflect current case law; subsequent decisions are less dismissive of the surrogate's authority but many courts still remain reluctant to give full recognition to the surrogate's consent, including one court that rejected an intent-based analysis because it relies on the "whims" of personal agreement.[129] The pre-*Roe* laws allowing abortion only when the woman's life or health was endangered denied women moral authority. In modern abortion legislation, this distrust emerges in biased informed consent laws and laws mandating waiting periods.[130] *Casey* describes the informed consent requirement at issue as a legitimate attempt "to ensure that a woman apprehend the full consequences of her decision," so that she will not "discover later, with devastating psychological consequences, that her decision was not fully informed."[131] *Casey* also approves a 24-hour waiting period, and a gendered stereotype, with this language: "[t]he idea that important decisions will be more informed and deliberate if they follow some period of reflection does not strike us as unreasonable…."[132]

These cases treat a woman's decision to abort or become a surrogate with gendered skepticism; a woman may be deemed capable of informed consent to all other major medical procedures but her decision not to become a mother justifies state intervention.

B. Expectation of Regret

A woman who cannot be trusted to make a moral and rational decision is likely to experience regret once she learns the "truth." The decision in *Gonzalez v. Carhart*, upholding the Federal Partial-Birth Abortion Ban Act, embraces the theory of regret when it opines, "While we find no reliable data to measure the phenomenon, it seems unexceptional to conclude some women come to regret their choice to abort the infant life they once created and sustained… Severe depression and loss of esteem can follow."[133] The expectation of regret derives from the same presumptions that attach stigma to abortion and surrogacy; (1) the biological fact of pregnancy ordains motherhood, and (2) it is unnatural for a mother to give up a child.[134] This supposition may lead to laws that question a woman's decision or shift authority from the woman to the government.[135] Expectation of regret may lead to the imposition of waiting periods, with surrogacy a post-birth limbo when the surrogate can change her mind, with abortion, a pre-procedure state-mandated reflection.[136]

Laws that deny women the capacity to give informed consent and anticipate profound female regret reflect a set of stereotypes that presumes the state has a role in protecting women from the consequences of their decisions.

C. Protection of Women

The woman protective rationale supposes that the decision not to become a mother is the result of poor judgment or duress. The expectation of emotional harm is tied, with abortion, to thoroughly discredited data concerning the existence of "post-abortion distress syndrome."[137] With surrogacy, the distraught images of the Baby M surrogate, Mary Beth Whitehead, widely published in the media, convinced an entire generation of lawmakers and the public of the need to protect women from becoming surrogates.

The woman protective strategy is a familiar and still prevalent approach to controlling women's reproduction. By assuming that maternity is the ordained and desirable consequence of pregnancy, the state shoul-

ders the role of protecting the woman from the harmful consequences of her decision. *Carhart*, describing the abortion decision as one "fraught with emotional consequences," concludes, "The State has an interest in ensuring so grave a choice is well informed."[138] The report of an abortion task force in South Dakota concluded the state should limit abortion for the protection of the woman because"[it] is so far outside the normal conduct of a mother to implicate herself in the killing of her own child."[139] The state's interference in reproductive decisions is described as protecting the "fundamental right [of a mother to have a] relationship with her child."[140] Similarly, one of the primary arguments against surrogacy is the assumption that the arrangement exploits surrogates. In one case, a Michigan appeals court rejected a constitutional "right to procreate" challenge to the state's surrogacy law, concluding that government intrusion into private procreative choices was warranted because the state has a compelling interest in preventing the exploitation of women.[141]

VI. Stigma and the Court

Stigma is a social construct; thus the question of the interplay between stigma and law necessarily implicates the broader question of the relationship between law and culture. Although that topic is beyond the scope of this paper, a few observations are useful. Law may mediate stigma in a variety of ways. Law may reinforce the social construction of stigma by converting moral disapproval into public policy through criminalization. Outside the criminal law, legal standards that differentiate individuals may reinforce stereotypes. Laws also may serve an expressive function, sending messages about behavior, identity, and moral value that reinforce stigma.[142] Conversely, stigmatizing laws that reflect discrimination or animus against certain minority groups may be evidence of constitutional harm.

The Supreme Court has considered the role of stigma in cases involving racial discrimination, criminal convictions, government employment, paternity determinations, and involuntary commitments.[143] Evidence of stigma may be relevant to determining constitutional harm under both the due process and equal protection clauses.[144] State reinforcement of negative stereotypes is particularly relevant to anti-subordination concerns under equal protection.[145] Several landmark cases focus on the harm caused by state-generated stigma.

In *Lawrence v. Texas*, the Court, in an opinion by Justice Kennedy, expressed concern about the stigma created by a law that criminalized homosexual sodomy.[146] The Court observed how moral disapproval embodied in law contributes to stigma and discrimination: "When homosexual conduct is made criminal by the law of the State, that declaration in and of itself is an invitation to subject homosexual persons to discrimination both in the public and in the private spheres."[147] Concluding that adult, consenting homosexuals have a constitutionally protected liberty interest in intimate relationships, the Court found that laws criminalizing same sex sodomy generate stigma irrespective of whether the laws are enforced: "[i]f protected conduct is made criminal and the law which does so remains unexamined for its substantive validity, its stigma might remain even if it were not enforceable as drawn for equal protection reasons."[148]

The decision in *U.S. v. Windsor*[149] highlights how stigmatic harm may result from civil laws that express moral disapproval of protected constitutional interests. The Court, in an opinion once again written by Justice Kennedy, finds that Section 3 of the Federal Defense of Marriage Act (DOMA) is an unconstitutional deprivation of equality. The Court concludes that DOMA stigmatizes homosexuals through moral disapproval and animus: "[t]he avowed purpose and practical effect of the law here in question are to impose a disadvantage, a separate status, and so a stigma upon all who enter into same-sex marriages made lawful by the unquestioned authority of the States."[150] This "differentiation," characteristic of stigma, demeans those "whose moral and sexual choices the Constitution protects."[151] The Court finds that the "principal purpose and the necessary effect" of DOMA are to "demean," "disparage," and "injure" individuals who are in a lawful same-sex marriage.[152]

The Court's description of stigma in *Windsor* reflects the pattern of disapproval, differentiation, and loss of status identified by Link and Phelan. *Windsor* articulates the relationship between moral disapproval, stigma, and constitutional harm. *Carhart*, in contrast, serves as an example of how judicial opinions can reinforce stereotypes and stigma. *Carhart* relies on stigmatizing language, describing physicians as "abortionists," fetal life as a "child," and an abortion as a "killing."[153] The Court's assumption, without "reliable data," that women may regret a decision to terminate a pregnancy relies on the same use of stereotyping that *Windsor* rejects.[154] Unlike *Lawrence* and *Windsor* and, indeed, *Casey*, *Carhart* accepts moral disapproval as a basis for regulation of abortion.[155]

The Court has also addressed the relationship between stigma and negative stereotyping. The decision in *Brown v. Board of Education*[156] relies substantially on the Court's conclusion that racially segregated schools stigmatized black children.[157] Other cases recognize that stigma may have a "very significant impact on the individual," including personal

and social harm.[158] The Court at times has criticized affirmative action laws for stigmatizing individuals through stereotyping.[159]

Laws that perpetuate negative stereotypes are a central concern in the Court's analysis of gender discrimination.[160] In *Nevada Dept. of Human Resources v. Hibbs*,[161] the Court, upholding the constitutionality of the mandatory leave provision of the *Family and Medical Leave Act*, cites congressional findings of widespread employment discrimination against women based on "pervasive presumptions that women are mothers first."[162] *Hibbs* recognizes that laws regulating pregnancy are particularly susceptible to stereotyping.[163] *Casey* acknowledges deeply embedded stereotypes associated with maternity when it concludes, "[h]er suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture."[164]

These cases recognize the relationship between stereotyping and stigma. When the state generates stigma or enforces social stigma, it participates in creating a pariah group that is likely to suffer loss of status or discrimination.

VII. Stigma and Laws Regulating Abortion and Surrogacy

Stigma is a particularly pervasive mechanism for regulating sexual conduct and reproduction.[165] Reproduction is not solely a private matter; state intrusion into reproductive decisions has a long history and derives from public concerns about population, protection of the family unit, and morality. The cultural shame associated with infertility and unwed motherhood has deep roots and continuing influence on public attitudes towards reproduction. Abortion has been socially stigmatized on moral and religious grounds for many years; not infrequently, conservative opponents of abortion condemn surrogacy because it relies on birth outside the marriage relationship. The bad mother stigma identified with abortion and surrogacy reveals the prevalence and durability of gendered stereotypes. Controversies surrounding abortion and surrogacy serve as highly visible platforms for social debate about the roles of women.

The role of law in the generation of stigma is complex, but in matters of reproductive decisions, the risk is high that restrictions imposed on women who terminate a pregnancy or become surrogates reflect gendered stereotypes of motherhood. That risk is particularly problematic given the constitutional significance of reproductive decision making. The solution in part is to assure that the relationship between stigma and gender stereotyping informs judicial consideration of laws regulating abortion and surrogacy. Evidence of stigma is probative both of how gender stereotypes may influence legislative purpose and assessment of the harm imposed by a regulation, for stigma may impact reproductive decisions and behavior.

Law serves as one medium for that dispute; in matters of sexual conduct and reproduction, law often serves to control morality through criminalization and stigma. The increasing separation and marginalization of abortion from other medical and reproductive health procedures reflect the process of stigmatization described by Link and Phelan. These laws designate women who choose abortion as "other." Gender stereotypes underlie abortion restrictions that contain exceptions for rape, incest, or serious medical risks for the woman.[166] These exceptions belie the state's claim that protection of prenatal life must always prevail. This good abortion/bad abortion binary, like the good mother/bad mother duality, reflects social judgment about when a woman may be "excused" from fulfilling the maternal role.[167] Similarly, laws that ban surrogacy or refuse to enforce surrogacy agreements directly stigmatize and also send powerful social messages that surrogacy is "bad" and the surrogate, the most visible manifestation of the arrangement, is aberrant.

The role of law in the generation of stigma is complex, but in matters of reproductive decisions, the risk is high that restrictions imposed on women who terminate a pregnancy or become surrogates reflect gendered stereotypes of motherhood. That risk is particularly problematic given the constitutional significance of reproductive decision making. The solution in part

is to assure that the relationship between stigma and gender stereotyping informs judicial consideration of laws regulating abortion and surrogacy. Evidence of stigma is probative both of how gender stereotypes may influence legislative purpose and assessment of the harm imposed by a regulation, for stigma may impact reproductive decisions and behavior.[168]

VIII. Conclusion

The harm of stigma to an individual is multi-faceted; physical and psychological stress is likely and those who internalize stigma suffer negative self-images. But regulating reproductive decisions through stigma harms not just the individual but also society. The state should not be a participant in the process of shaming women for their reproductive decisions; such actions deny women moral agency. Law instead should be a means for contesting stigma associated with gendered stereotypes, particularly those stereotypes that undermine reproductive decision making. Martha Nussbaum, in her analysis of the role of shame and disgust in the law, rejects the use of public laws to stigmatize individuals, "for the state to participate in this humiliation…is profoundly subversive of the ideas of equality and dignity on which a liberal society is based."[169]

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References

1. H. Ragoné, "Chasing the Blood Tie: Surrogate Mothers, Adoptive Mothers and Fathers," *American Ethnologist* 23, no. 2 (1996): 352-365, at 353.
2. *Id*., at 353.
3. For the distinction between traditional surrogacy and gestational surrogacy, see note 48, *infra*, and related text. The bad mother moniker may attach to either arrangement.
4. *Gonzales v. Carhart*, 550 U.S. 159 (2007)
5. C. E. Miall, "Community Constructs of Involuntary Childlessness: Sympathy, Stigma, and Social Support," *Canadian Review of Sociology and Anthropology* 31, no. 4 (1996): 392-421.
6. O. B. A. van den Akker, "Psychosocial Aspects of Surrogate Motherhood," *Human Reproduction Update* 13, no. 1 (2007): 53-62, at 56 [hereinafter "Psychological Aspects"].
7. See Ragoné, *supra* note 1, at 360.
8. Both practices also challenge the traditional conception of family. See, e.g., M. A. Field, *Surrogate Motherhood* (Cambridge, Mass: Harvard Univ. Press, 1988): at 33 (arguing that surrogacy raises fears about our understanding of family).
9. See Ragoné, *supra* note 1, at 360.
10. See "Psychological Aspects," *supra* note 6, at 55.
11. See *Muller v. Oregon*, 208 U.S. 412, 422 (1908) (referring to the importance of maternal function to the "well-being of the race").
12. See, e.g., *Muller*, 208 U.S. at 421 (describing that her physical structure and a proper discharge of her maternal functions – having in view not merely her own health, but the wellbeing of the race – justify legislation to protect her from the greed, as well as the passion, of man).
13. C. E. Miall, "The Stigma of Involuntary Childlessness," *Social Problems* 33, no. 4 (1986): 268-282, at 270. Infertility is not solely a biological condition; individuals may be socially infertile for a variety of reasons, including lack of affordable access to infertility treatments, or, in the case of single individuals or same sex couples, because they must rely on means other than sexual intercourse with a partner. See M. M. Shultz, "Reproductive Technology and Intent-Based Parenthood: An Opportunity for Gender Neutrality," *Wisconsin Law Review* no. 2 (1990): 297-398; O. B. A. van den Akker, "The Acceptable Face of Parenthood: The Relative Status of Biological and Cultural Interpretations of Offspring in Infertility Treatment," *Psychology, Evolution & Gender* 3.2 (2001): 137-153, at 138 [hereinafter "Acceptable Face of Parenthood"]; J. Daar, "Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms," *Berkeley Journal of Gender, Law & Justice* 23, no. 1 (2008): 18-82, at 24. Regardless of the source, infertility is stigmatized and this stigma shapes social attitudes toward personal identity, family, sexuality, and reproduction. See Miall at 270. See generally Miall, *supra* note 5 (studying stigma and infertility). Research has correlated the reaction to infertility with grief. See A. E. Poote and O. B. A. van den Akker, "British Women's Attitudes to Surrogacy," *Human Reproduction* 24, no. 1 (2009): 139-145.
14. See Miall, *supra* note 13, at 270; A. S. Rossi and B. Sitaraman, "Abortion in Context: Historical Trends and Future Changes," *Family Planning Perspectives* 20, no. 6 (1988): 273-281+381, at 275. Issues of race and class attach to social incentives to reproduce. See generally, K. M. Franke, "Theorizing Yes: An Essay on Feminism, Law, and Desire," *Columbia Law Review* 101, no. 1 (2001): 181, 186-195 (defining assumptions regarding reproduction as "repronormativity").
15. The social value of mothering may also be deeply impacted by racial politics. See, e.g., S. Markens, *Surrogate Motherhood and the Politics of Reproduction* (Berkeley: University of California Press, 2007): at 12-13.
16. *Id*., at 11.
17. C. Sanger, "Separating from Children," *Columbia Law Review* 96, no. 2 (1996): 375-517, at 424, 453.
18. R. B. Siegel, "The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions," *University of Illinois Law Review* 2007, no. 3 (2007): 991-1054, 1029.
19. See Markens, *supra* note 15, at 163-165.
20. R. Macklin, "Is There Anything Wrong with Surrogate Motherhood," in L. Goslin, *Surrogate Motherhood, Politics and Privacy* (Bloomington: Indiana University Press,1990): at 136; C. Cahill, "Abortion and Disgust," *Harvard Civil Rights-Civil Liberties Law Review* 48 (2013): 409-456.
21. J. Strickler and N. L. Danigelis, "Changing Frameworks in Attitudes toward Abortion," *Sociological Forum* 17, no. 2 (2002): 187-201, at 200.
22. See Markens, *supra* note 15, at 83.
23. See, e.g., S. Saravanan, "An Ethnomethodological Approach to Examine Exploitation in the Context Of Capacity, Trust and Experience of Commercial Surrogacy in India," *Philosophy, Ethics and Humanities in Medicine* 8, no. 1 (August 20, 2013): 10.
24. E. Goffman, *Stigma: Notes on the Management of Spoiled Identity* (New York: Simon & Schuster, Inc., 1963): at 3.
25. K. M. Shellenberg, "Abortion Stigma in the United States: Quantitative and Qualitative Perspectives from Women Seeking an Abortion," (April 2010), at 11 (unpublished Ph.D. dissertation, Johns Hopkins University) (on file with Milton S. Eisenhower Library, Johns Hopkins University).
26. *Id*., at 4-5. Goffman also describes stigma associated with visible physical traits. *Id.*
27. K. Cockrill and A. Nack, "I'm Not That Type of Person": Managing the Stigma of Having an Abortion," *Deviant Behavior* 34, no. 12 (2013): 973-990, at 974.
28. *Id*., at 974.
29. *Id.*

30. See Goffman, *supra* note 24, at 128; R. J. Cook and B. M. Dickens, "Reducing Stigma in Reproductive Health," *International Journal of Gynecology & Obstetrics* 125, no. 11 (2014): 89-92 at 90.
31. B. G. Link and J. C. Phelan, "Conceptualizing Stigma," *Annual Review of Sociology* 27, no. 1 (2001): 363-385 at 367.
32. See Link and Phelan, *supra* note 31, at 375.
33. See Joyce T. J. et al., *The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review* (New York: Guttmacher Institute, 2009): at 11 (citing one survey that showed costs for low-income women increased by 48% when a second visit to the provider was required).
34. K. Kimport, K. Cockrill, and T. Weitz, "Analyzing the Impacts of Abortion Clinic Structures and Processes: A Qualitative Analysis of Women's Negative Experience of Abortion Clinics," *Contraception* 85, no. 2 (2012): 204-210, at 207.
35. J. C. Ciccarelli and L. J. Beckman, "Navigating Rough Waters: An Overview of Psychological Aspects of Surrogacy," *Journal of Social Issues* 61, no. 1 (2005): 21-43, at 29.
36. *Id*., at 30-31; P. Laufer-Ukeles, "Mothering for Money: Regulating Commercial Intimacy," *Indiana Law Journal* 88, no.4 (2013): 1223-1279, at 1234.
37. *Id.*
38. *Id.*
39. See, e.g., Cockrill and Nack, *supra* note 27, at 979; A. Kumar et al., "Conceptualising Abortion Stigma," *Culture, Health and Sexuality* 11, no. 6 (2009): 625-639, at 629; P. C. Dunn, I. J. Ryan, and K. O'Brien, "College Students' Acceptance of Adoption and Five Alternative Fertilization Techniques," *Journal of Sex Research* 24, no.1 (1988): 282-287; Poote and van den Akker, *supra* note 13.
40. See Shellenberg, *supra* note 25, at 39.
41. See Kumar et al., *supra* note 39, at 629.
42. See Ciccarelli and Beckman, *supra* note 35, at 22-23.
43. See Cockrill and Nack, *supra* note 27, at 979; "Psychological Aspects, *supra* note 6, at 57.
44. Kumar et al., *supra* note 39, at 629.
45. See, e.g., "Acceptable Face of Parenthood," *supra* note 13, at 149.
46. See, e.g., Ciccarelli and Beckman, *supra* note 35, at 23.
47. See Markens, *supra* note 15, at 17-18.
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49. *Id.*
50. *Id*., at 139.
51. See G. Bernstein, "Unintended Consequences," *Indiana Health Law Review* 10, no. 2 (2013): 291-324, at 311-318.
52. See "Psychosocial Aspects," *supra* note 6, at 55.
53. See "Acceptable Face of Parenthood," *supra* note 13, at 138.
54. M. Warnock et al., "Report of the Committee of Inquiry into Human Fertilisation and Embryology" (1984) [hereinafter Warnock Report].
55. *Id*., at 45.
56. *Id*., at 43.
57. *Id*., at 44.
58. *Id*., at 46.
59. Surrogacy Arrangements Act, 1985; Human Fertilization and Embryology Authority Act, 1990.
60. *In re Baby M*, 537 A2d 1227 (N.J. 1988).
61. *Id*., at 1241-1242.
62. See Scott, *supra* note 48, at 117.
63. *Id*., at 135.
64. See Ciccarelli and Beckman, supra note 35; Poote and van den Akker, *supra* note 13, at 140; "Psychosocial Aspects," *supra* note 6, at 58.
65. M. Hansen, "As Surrogacy Becomes More Popular, Legal Problems Proliferate," *ABA Journal - Law News Now*, March 2011, *available at* <http://www.abajournal.com/magazine/article/as_surrogacy_becomes_more_popular_legal_problems_proliferate/> (last visited March 25, 2015). By contrast, surrogacy is highly regulated in most other industrial nations. See Markens, *supra* note 17, at 23.
66. See Poote and van den Akker, *supra* note 13, at 140-144.
67. See Ciccarelli and Beckman, *supra* note 35, at 29.
68. See "Psychosocial Aspects," *supra* note 6, at 57. Some commentators argue that a surrogate's contentment with her decision is no more than an "ironic self-deception" because it may be reinforcing oppressive gender roles. See M. J. Radin, "Market-Inalienability," *Harvard Law Review* 100, no. 8 (1987): 1849-1937, at 1930.
69. O. B. A. van den Akker, "Psychological Trait and State Characteristics, Social Support and Attitudes to the Surrogate Pregnancy and Baby," *Human Reproduction* 22, no. 8 (2007): 2287-2295, at 2293-2294 [hereinafter Psychological Trait].
70. See Ciccarelli and Beckman, *supra* note 35, at 33.
71. See "Psychosocial Aspects," *supra* note 6, 53-62; Poote and van den Akker, *supra* note 13, at 140.
72. Cardinal W. Levada, Prefect of the Congregation for the Doctrine of the Faith, "Dignitas Personae" (May 16, 2009). *Catechism of the Catholic Church* § 2376 states:

    Techniques that entail the dissociation of husband and wife, by the intrusion of a person other than the couple (donation of sperm or ovum, surrogate uterus), are gravely immoral." *Catechism of the Catholic Church* § 2376 (New York: Doubleday, 2d ed. 1997) (citing CDF, Donum vitae II, 1).
73. J. F. Sullivan, "Bishops File Brief Against Surrogate Motherhood," *New York Times*, July 19, 1987, at 28.
74. See Ragoné, *supra* note 1, at 354.
75. See "Psychosocial Aspects," *supra* note 6, at 56.
76. See Ragoné, *supra* note 1, at 356.
77. *Id*. Testimony of altruistic motives helped sway a 1989 California state legislative committee to authorize noncommercial surrogacy.
78. See "Psychosocial Aspects," *supra* note 6, at 56.
79. "Baby Mama" is one example of a highly popular film that depicted the commercial surrogate as unemployed, uneducated, and scheming.
80. See Scott, *supra* note 48, at 140.
81. The use of surrogacy is increasing, particularly among same-sex couples. A. Hartocollis, "And Surrogacy Makes 3," *New York Times*, February 19, 2014, *available at* <http://www.nytimes.com/2014/02/20/fashion/In-New-York-Some-Couples-Push-for-Legalization-of-Compensated-Surrogacy.html?hp> (last visited March 25, 2015).
82. Certainly some scholars argue that maternal identity is established through pregnancy, not through the genetic link. Research on adoption suggests maternal identity can be formed through nurturance. See, generally, B. Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society* (New York: WW Norton & Co., 1990).
83. See, e.g., *In re C.K.G.*, 173 S.W.3d 714, 729 (2005), *Belsito v. Clark*, 644 N.E.2d 760, 763 (1994).
84. R. F. Kandel, "Which Came First: The Mother or the Egg? A Kinship Solution to Gestational Surrogacy," *Rutgers Law Review* 47, no. 1 (1994): 165-239, at 188.
85. R. K. Jones, L. B. Finer, and S. Singh, *Characteristics of U.S Abortion Patients, 2008* (New York: Guttmacher Institute, 2010): at 12.
86. A. Norris et al., "Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences," *Women's Health Issues* 21, Supp. (2011): S49-S54, at S51.
87. See, e.g., B. Major et al., "Abortion and Mental Health: Evaluating the Evidence," *American Psychologist* 64, no. 9 (2009): 863-890, at 867; L. L. Littman et al., "Introducing Abortion Patients to a Culture of Support: A Pilot Study," *Archives of Women's Mental Health* 12, no. 6 (2009): 419-431, at 421; B. Major and R. H. Gramzow, "Abortion as Stigma: Cognitive and Emotional Implications of Concealment," *Journal of Personality and Social Psychology* 77, no. 4 (1999): 735-745, at 735.
88. See Cockrill and Nack, *supra* note 27, at 973.

89. R. W. Bourne, "Abortion In 1938 and Today: Plus Ça Change, Plus C'est La Même Chose," *Southern California Review of Law & Women's Studies* 12, no. 2 (2003): 229-275, at 247.
90. J. C. Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800-1900* (New York: Oxford University Press, 1978): at 241-244.
91. *Id*., at 104-108.
92. *Id*., at 108.
93. See Norris et al., *supra* note 86, at S52.
94. *Id.*
95. See T. W. Smith and J. Son, "Trends in Public Attitudes towards Abortion" (2013), *NORC Final Report*.
96. *Id.*, at 6, 7.
97. *Id.*
98. *Id*., at 2, 6. Abortion is approved where there is a serious health risk (87%), rape (78.3%), or serious fetal abnormality (77.1%). *Id*., at 2. Inability to afford a child (40.6%), married, wants no more children (43.2%), any reason (41.7%). *Id*., at 2, 6-7.
99. 505 U.S. 833 (1992).
100. See Smith and Son, *supra* note 95, at 7; T. G. Jelen and C. Wilcox, "Causes and Consequences of Public Attitudes toward Abortion: A Review and Research Agenda," *Political Research Quarterly* 56, no. 4 (2003): 489-500, at 491.
101. See Bourne, *supra* note 89, at 229, 273.
102. See Kumar et al., *supra* note 39, at 629.
103. See Shellenberg, *supra* note 25, at 16.
104. See *id*., at 19, 183, 194-199; Major et al., *supra* note 87, at 885 (noting that abortion is often hallmarked by ambivalence); Jones, Finer, and Singh, *supra* note 85, at 11 (discussing health insurance coverage and payment for abortion services); Littman et al., supra note 87, at 421-422 (discussing common types of abortion misinformation).
105. See Shellenberg, *supra* note 25, at 183-184, 192-193. See B. Major et al., APA Task Force on Mental Health and Abortion *Report of the APA Task Force on Mental Health and Abortion* 90 (2008) (noting that at least one study showed that a majority of women experienced no regret upon deciding to abort for fetal abnormality, and that generally, the evidence supports the assertion that the mental health risks are no greater among adult women who experience unplanned pregnancies who decide to abort than those who decide to deliver that pregnancy).
106. See Shellenberg, *supra* note 25, at 192.
107. See Littman et al., supra note 87, at 428.
108. See Shellenberg, *supra* note 25, at 183.
109. K. Kimport, "(Mis)understanding Abortion Regret," *Symbolic Interaction* 35, no. 2 (2012): 105-122, at 111.
110. See Norris et al., supra note 86, at S50. Stigma need not be attached to a visible trait. Goffman, *supra* note 24, at 48-51.
111. *Id.* See Kumar et al., *supra* note 39, at 632 (noting that stigma and the associated status loss "is most often articulated at the community and social network levels").
112. K. Cockrill et al., "The Stigma of Having an Abortion: Development of a Scale and Characteristics of Women Experiencing Abortion Stigma," *Perspectives on Sexual and Reproductive Health* 45, no. 2 (2013): 79-88, at 80.
113. See Shellenberg, *supra* note 25, at 200.
114. *Id.*
115. See Cockrill and Nack, *supra* note 27, at 975.
116. See Major et al., *supra* note 87, at 867.
117. See Major and Gramzow, *supra* note 87, at 741-742. Other factors include the extent to which a woman wanted and felt committed to her pregnancy, perceived self-efficacy for coping with the abortion, low actual or anticipated social support for the abortion decision, and use of avoidance and denial coping strategies. *Id.*
118. See Major et al., *supra* note 87, at 867.
119. *Id.*
120. See Kumar et al., *supra* note 39, at 629; see Norris et al., *supra* note 86, at S50 (noting that stigma may be episodic for some abortion patients who experience the reemergence of their stigma when prompted).
121. See Kimport, *supra* note 109, at 107.
122. See Kumar et al., *supra* note 39, at 634.
123. *Id*., at 629.
124. See Kimport, *supra* note 109, at 128.
125. P. Abrams, "The Tradition of Reproduction," *Arizona Law Review* 37, no. 2 (1995) 453-470, at 463-470.
126. Consideration of the stigma experienced by the Intended Mother (IM) is beyond the scope of this paper but a few points are worth noting. The stigma that attaches to the practice of surrogacy is likely a common experience for both the surrogate and the IM. An IM may also have to confront stigma associated with infertility. On the other hand, IMs may benefit from greater social support than surrogates. See "Psychological Trait, *supra* note 69, at 2293.
127. See, e.g., M. Manian, "Irrational Women: Informed Consent and Abortion Regret," in T. A. Thomas and T. Jean Boisseau, eds., in *Feminist Legal History: Essays on Women and Law* (New York: New York University Press, 2011): at 118.
128. *In re Baby M*, 537 A.2d 1227, 1248 (N.J. 1988).
129. See, e.g., *Johnson v. Calvert*, 851 P.2d 776, 785 (1993), applying an intent-based test, "The argument that a woman cannot knowingly and intelligently agree to gestate and deliver a baby for intending parents carries overtones of the reasoning that ...prevented women from obtaining equal economic rights and professional status under the law." But see, *Belisto v. Clark*, 644 N.E.2d 760, 766 (1994), refusing to apply Johnson. See also In re Marriage of Moschetta, 30 Cal.Rptr.2d 893 (1994), refusing to apply Johnson to a traditional surrogacy dispute.
130. See, e.g., Miss. Code Ann. § 41–41–33 (West 1996); 18 Pa. Cons. Stat. Ann. § 3205 (West 1989); Wis. Stat. Ann. § 253.10(3)(a)–(c) (West 2011).
131. *Casey*, 505 U.S. at 882
132. *Id*., at 885.
133. *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007).
134. L. Andrews, "Surrogate Motherhood: The Challenge for Feminists," in L. Gostin, ed., *Surrogate Motherhood: Politics and Privacy* (Bloomington and Indianapolis: Indiana University Press, 1990): at 167, 171.
135. *Id*., at 172.
136. See, e.g., *A.H.W. v. G.H.B*, 772 A.2d 948 (2000) (mandating 72 hour period after birth for gestational surrogate to decide whether to surrender the baby), *R.R. v. M.H.*, 426 Mass. 501 (1998)(holding traditional surrogacy agreement unenforceable because it did not allow the surrogate four days after birth to change her mind). See also, 168-B:25 N.H. Rev. Stat. Ann.(2008), requiring minimum 72 hour period after birth for surrogate to reconsider her agreement. See, e.g., *Gonzales v. Carhart*, 550 U.S. 124, 159–60 (2007) ("It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.")
137. Brief for Amicus Curiae Am. Psychological Ass'n in Support of Appellees at 14, *Webster v. Reprod. Health Servs*., 492 U.S. 490 (1989) (No. 88–605), 1989 WL 1127695 at *14. See also L. Greenhouse, "How the Supreme Court Talks about Abortion: The Implications of a Shifting Discourse," *Suffolk University Law Review* 42, no. 1 (2008): 41-59, 47-48. The Carhart majority opinion thus adopts the discredited theory of a "postabortion syndrome" that inflicts lasting emotional damage on women who have had abortions. Although embraced by such organizations as Feminists for Life of America, where Jane Sullivan Roberts, the wife of Chief Justice Roberts, once served as executive vice president of the board of directors and currently as pro bono legal counsel, the theory has been widely debunked in the medical literature. *Id*., at 56 (citing K.-A. Kinorski, "The Aftermath of Abortion," *American Feminist* 5, no. 1 (1998): 6-7).

138. *Carhart*, 550 U.S. at 159.
139. S. D. Task Force to Study Abortion, *Report of the South Dakota Task Force to Study Abortion* (2005): at 56 [hereinafter Task Force Report].
140. *Id.*, at 65.
141. *Doe v. Attorney General*, 487 N.W.2d 484, 487 (1992). See, also, Andrews, *supra* note 134, at 171.
142. S. Burris, "Disease Stigma in U.S. Public Health Law," *Journal of Law, Medicine & Ethics* 30, no. 2 (2002): 179-190, at 184.
143. See, e.g., *Brown v. Bd. of Educ. of Topeka*, 347 U.S. 483 (1954) (racial discrimination); *Bd. of Regents of State Coll. v. Roth*, 408 U.S. 564 (1972) (employment); *Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701 (2007); *Addington v. Texas*, 441 U.S. 418 (1979) (involuntary commitment); *Codd v. Velger*, 429 U.S. 624 (1977) (employment).
144. See, e.g., *Bd. of Regents of State Coll.*, 408 U.S. at 573 (discussing potential due process issues). See, e.g., *id.* at 573-575; *Rivera v. Minnich*, 483 U.S. 574 (1987); *Addington*, 441 U.S. at 426; *Beard v. Stahr*, 370 U.S. 41, 42-45 (1962) (Douglas, J., dissenting).
145. See, e.g., *Rivera v. Minnich*, 483 U.S. 574, 585 (1987) (Brennan, J., dissenting); *Lawrence v. Texas*, 539 U.S. 558, 575 (2003).
146. *Lawrence*, 539 U.S. at 575-576.
147. *Id.*
148. *Id.*, at 575 See *id.*, at 571 ("The issue is whether the majority may use the power of the State to enforce these views on the whole society through operation of the criminal law."); see also *id.*, at 586-605 (Scalia, J., dissenting).
149. *United States v. Windsor*, 133 S.Ct. 2675 (2013).
150. *Windso*r, 133 S.Ct. at 2693.
151. *Id.*, at 2694.
152. *Id.*, at 2695-2696.
153. *Carhart*, 550 U.S. at 159.
154. *Id.*
155. *Id.*, at 158 ("Congress could…conclude…the Act…implicates… ethical and moral concerns that justify a special prohibition.") But see, Casey, 505 U.S. at 850 ("Our obligation is to define the liberty of all, not to mandate our own moral code.")
156. 347 U.S. 483 (1954).
157. *Brown*, 347 U.S. at 494 (1954). See also R. A. Lenhardt, "Understanding the Mark: Race, Stigma, and Equality in Context," *New York University Law Review* 79, no. 3 (2004): 803-931 (arguing that racial stigma, not intentional discrimination, is the source of racial injury).
158. *Addington v. Texas*, 441 U.S. 418, 426 (1979); see also *Patterson v. New York*, 432 U.S. 197, 226 (1977) (Powell, J., dissenting); *Beard v. Stahr*, 370 U.S. 41, 42-45 (1962) (Douglas, J., dissenting).
159. See *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 491 (1989) ("Classifications based on race carry a danger of stigmatic harm."); *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 516 (1989) (Stevens, J., concurring) ("There is a special irony in the stereotypical thinking that prompts legislation of this kind. Although it stigmatizes the disadvantaged class with the unproven charge of past racial discrimination, it actually imposes a greater stigma on its supposed beneficiaries."); *Grutter v. Bollinger*, 539 U.S. 306, 349-378 (2003) (Thomas, J., concurring in part, dissenting in part); *Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701, 748-782 (2007) (Thomas, J., concurring).
160. *United States v. Virginia*, 518 U.S. 515, 533 (1996); see also *Frontiero v. Richardson* 411 U.S. 677 (1973).
161. 538 U.S. 721 (2003).
162. *Id.*, at 736.
163. *Id.*
164. *Casey*, 505 U.S. at 852
165. See Cook and Dickens, *supra* note 30, at 91. See also, *Lawrence v. Texas*, discussed, *supra* note 146.
166. See, e.g., *Dep't of Labor, Health and Human Services, and Education, and related Agencies Appropriations Act*, 1994, Pub.L. No. 103-112, (107 Stat. 1082) [hereinafter Hyde Amendment)].
167. See Smith and Son, *supra* note 95, at 6-7.
168. Stigma evidence thus bears particularly on application of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, which requires inquiry into both the purpose and burden of a law regulating abortion. *Planned Parenthood Southeast v. Strange*, 2014 WL 1320158 (2014), is the first case to require consideration of stigma in assessing the burden imposed by restrictions on abortion. The Court has yet to consider whether the constitutional protection accorded the decision whether to bear or beget a child extends to noncoital conception such as surrogacy or other forms of ART. See J. A. Robertson, *Children of Choice: Freedom and the New Reproductive Technologies* (New Jersey: Princeton University Press, 1994): at 22-42.
169. M. Nussbaum, *Hiding from Humanity: Disgust, Shame, and the Law* (Princeton: Princeton University Press, 2004): at 232.