HER BODY, NO BABY: COMPULSORY PROCREATIVITY, THE STIGMA OF CHILDLESSNESS, AND U.S. EXCEPTIONALISM IN THE ERA OF TECHNOSCIENCE

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INTRODUCTION

Compulsory procreativity is the term I use to describe the biopolitical compulsion to reproduce, usually genetically, to which (most) women in the United States are subject. In this project, I am investigating the stakes of various means of biomedicalization of women's bodies. I argue, using Foucault's theory of biopower, that women feel a compulsion to reproduce genetically rather than adopt. On the other hand, I argue that the same technoscientific advances used to treat infertility are being used to further stratify women across lines of race and class through surrogacy programs. While previous theory has critiqued the idealization of motherhood, I propose feminist theory look to queer theory to critique instead the idealization of genetic reproduction, to critique this compulsory procreativity. Adrienne Rich coined the phrase “compulsory heterosexuality” to explicate how patriarchy worked to figure lesbian relations as nonnormative; while she argued that such relations are natural, my compulsory procreativity shifts emphasis to the new biopolitics at work to figure the childless and childfree woman as nonnormative, as queer. To undertake my study, I must, of course, examine how feminism has addressed reproduction and reproductive rights in the past and how feminism, given biomedicalization, is addressing reproduction now. Simone de Beauvoir writes in her book *The Second Sex* (1949) that reproduction was one means of men controlling women and their bodies. Second Wave feminism furthered the fight for reproductive agency, fighting for birth control and fighting against compulsory sterilization (for some women). Dorothy Roberts’ work *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* is especially helpful to my project’s consideration of compulsory sterilization since the work fuses law, feminism, and critical race theory to critique biomedicalization. While the few examples I have given here are
hardly exhaustive of the work of three waves of feminism, they are some examples that I concern myself with in this project. I will investigate the ways in which new female subjectivities are being borne out of this compulsion to reproduce in the late-twentieth and twenty-first centuries within the child-centered U.S. society, a shift that I will explore using Viviana Zelizer’s *Pricing the Priceless Child: The Changing Social Value of Children*.

So, while Beauvoir argued that the perpetuation of the family (i.e., reproduction) was a means of oppressing women, Shulamith Firestone in *The Dialectic of Sex: The Case for Feminist Revolution* (1970) argued that reproductive technologies would “free” women from traditional modes of reproduction, allowing for gender equality in childbearing and childrearing. I argue that this perpetuation still exists, though in new forms, and that these new reproductive technologies are yet another means of oppressing women. Indeed, most of this project will engage with biomedicalization of the female body through technoscience, as technoscientific interventions in the body compel (some) women to submit to biomedicine in order to fulfill their “biological duty” to procreate. These interventions are shifting queerness from the figural homosexual to the childless or childfree woman while simultaneously further stratifying women. Laura Mamo’s *Queering Reproduction: Achieving Pregnancy in the Age of Technoscience* and Lee Edelman’s *No Future: Queer Theory and the Death Drive* will inform much of this scholarship as I use these works to consider both the biomedical consequences of the Child as emblematic of futurity.

While I will be referencing and analyzing previous arguments, part of my work will be to examine the unfolding archives of internet forums wherein people debate issues of reproduction (and thus issues of abortion, sterilization, and motherhood); this analysis will show how the childfree (and sometimes childless) woman is stigmatized as nonnormative, queer, and selfish.
Using Edelman and Foucault, I will consider the role of biopower in compelling some women to reproduce, in compelling some women to abstain from reproduction, and in stigmatizing women without children. I will examine how stigma has changed since the proliferation of the internet and personal computers. Is it possible for women to reject childbearing, especially when the message of the inescapable media calls upon women to procreate, disallowing infertility to be an “excuse” for childlessness and allowing little room for the choice of a childfree life? In other words, I will examine how the modern day childless/childfree woman experiences compulsory procreativity and the stigmatization of her subjectivity. While other theorists rightly have argued that the scientific interventions in the female reproductive system have only seemingly created freedom of choice for women, I argue that the proliferation and normalization of biomedical intervention in the female body has shifted queerness in part to those women who do not bear children, who do not capitulate to the norm of compulsory procreativity. Another part of my work in explicating the stratification of women across lines of race and class will be to analyze the emergence of the surrogacy phenomenon, using as one example the *New York Times* article “Her Body, My Baby,” from which I take my title. I will also use the documentary *Google Baby*, which will be especially helpful in my conclusion and in my consideration of the role of U.S. exceptionalism in compulsory procreativity.

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*The New Yorker* recently published an article by Elizabeth Kolbert titled “The Case Against Kids” with the tagline that asks “Is procreation immoral?” Kolbert is examining the issue of world overpopulation, using bioethics, philosophy, and economics. However, her invocation of morality speaks to a public perception that equates procreation with morality; so Kolbert asks, “Is procreation immoral?” in order to critique the norm that assumes procreation to
be indeed a moral act. Though I am not investigating population growth and though the morality of that particular issue is not at the center of this project, there are some assumptions about procreation that Kolbert uses to explicate why people choose to reproduce at all. These (bioethical and philosophical) perceptions are the reasons that underscore procreation as a moral act, which in turn fosters stigma around those who do not conform, who do not procreate.

Procreation is a biological urge.

To address the bioethics of procreation, Elizabeth Kolbert uses Christine Overall’s Why Have Children?: The Ethical Debate, in which Overall “dismisses the notion that childbearing is ‘natural’ and therefore needs no justification” (Kolbert 78). Kolbert, quoting Overall, states, “‘There are many urges apparently arising from our biological nature that we nonetheless should choose not to act upon,’ she [Overall] observes. If we’re going to keep having kids, we ought to be able to come up with a reason” (78). And people do give plenty of reasons, but Kolbert and Overall’s dismissal of a central argument in favor of reproduction seems almost too quick. Most people would agree that we should refrain from acting upon every biological urge, but childbearing/childrearing are often framed as joyous times in a person’s life. And so this (so-called) biological urge is acceptable (and often encouraged).

Parenthood will make the parent(s) happy.

People often argue that parenthood (or for my project, motherhood) will increase their overall happiness. While there is certainly an argument and potentially generative phenomenological investigation of the link between “happiness” and children, I would like to work simply with the assumption that childbearing/childrearing creates happiness. As Kolbert
reports, “Research shows that people who have children are no more satisfied with their lives than people who don’t. If anything, the balance tips the other way: parents are less happy. […] But none of this really matters. Procreation for the sake of the parents is ethically unacceptable. ‘To have a child in order to benefit oneself is a moral error,’ Overall writes” (Kolbert 79).

Importantly though, if parenting is supposed to be joyous, then, as I will investigate in this project, those who do not parent are those who are not joyous. Despite the studies that show parents to be no more satisfied than childless and childfree people, the pervading assumption is that parenthood makes parents happy; to question otherwise would be, in a society in which people are encouraged to pursue happiness, to question the purpose of parenthood.

Responsible citizens procreate to contribute to society.

Perpetuating one’s genetic lineage is another reason people have for procreating. Further, “[o]thers say that it’s a citizen’s duty to society to provide for its continuation. Such an obligation, Overall objects, ‘would make women into procreative serfs’” (Kolbert 79). Christine Overall’s statement may be somewhat hyperbolic, but there is a truth to the notion of “procreative serfs.” While, at least in the United States, women are not secluded and used only for reproductive purposes, like the plot of a dystopian fiction, women are still expected to procreate. As I will investigate in the latter part of this project, perhaps some women are treated like procreative serfs.

Some people have an ethical obligation to procreate (while others should not).

While I am arguing that compulsory procreativity is a normative force that compels women to genetically procreate, I have to acknowledge that not all women feel this compulsion.
Issues of class, race, and, as Kolbert points out, physical constitution actually influence and can counter compulsory procreativity. Kolbert references David Benatar’s *Better Never to Have Been: The Harm of Coming Into Existence* for an example of a couple who would be discouraged from reproducing. Benatar says that a young, rich couple both possessing genetic diseases would “have an ethical obligation not to procreate” (Kolbert 79). Benatar writes, “Those with reproduction-enhancing beliefs are more likely to breed and pass on whatever attributes incline one to such beliefs” (Kolbert 79-80). While I will address issues of race and class in this project, I think it is also helpful to consider the issue of genetics for a moment. Advances in technology have given us the ability to move beyond superficial medical diagnoses to the level of cellular analysis. Along with such analysis has come the desire to enhance the future, to decrease genetic disease in one’s progeny. This shift is called biomedicalization, and it is central to my project.

**Biomedicalization**

Because I am addressing issues of the (female) body and the biological, I depend on three main terms to articulate my thesis: biomedicine, biomedicalization, and biopower. Since the science of biology did not arise until the mid-1800s, it can be said that biology is culturally constructed in that its ideology is shaped differently depending upon the socio-temporal moment. While these terms are all concerned with *bios*, they all contribute to the hierarchical institutions of society that (pre)serve and value some people more than others.

First, the term biomedicine refers in particular to Western medicine that is concerned with the biological and must therefore be culturally constructed, or sociocultural. This sociocultural biomedicine privileges a hierarchical division of labor through specialized knowledge and, importantly, is dynamic, changing through centuries. Enlightenment thought has
influenced the philosophies of biomedicine; in this three pillars of biomedicine appear: the separation of the mind and the body, the argument for man as a machine, and the argument for the possibility of finding “truth.” This forms the basis for biomedicalization. If man, i.e. the body, is a machine, then it can be argued that the machine can be found in two states: functioning or malfunctioning. Thus if the body qua machine is malfunctioning then it must be capable of being repaired. This brings us not to biomedicalization yet but rather to medicalization, an important consideration before biomedicalization.

Medicalization is the “process through which aspects of life previously outside the realm of medicine come to be construed as medical problems” for which biomedicine is the “cure” (Clarke et al. 47). Characteristics previously construed as deviant (and signifiers of immorality) became signifiers of illness, falling under the jurisdiction of medicine. The Enlightenment belief in a comprehensible “truth” influenced the medical belief in a “cure.” Thus, in seeking cure, they appeared to be seeking truth, ultimately at the cost of normalizing life processes and creating the binary of what we know as healthy (a fully-functional machine) and diseased (a malfunctioning machine). Health maintenance became social with the rise of institutions like hospitals and clinics, and people began to internalize these medical conceptualizations and diagnoses, causing “health” to become an issue of morality (Clarke et al. 48), an issue I’ll address in Chapter Two.

Medicalization, which spanned from 1945 to 1985, operated at the level of organs and cells (Clarke et al. 50-1). However, contemporaneously, biomedicalization saw the furtherance of that operation to the level of genes, proteins, and molecules (Clarke et al. 47).

Biomedicalization is similar to medicalization in that it is complex and dynamic; however, biomedicalization is medicalization through technoscience, or through the intervention of technology in medicine and the body (Clarke et al. 47). Whereas medicalization sought a cure
for illnesses, biomedicalization seeks a *prevention* of illness. Whereas before people were either "healthy" or "ill," through biomedicalization, the discourse changes to one of "risk" levels; in a sense, people are always already ill, either at a high-risk or a low-risk for disease. Individuals are expected to “manage” their health, i.e. to conform to the normative constructions of health, and to minimize their risk in order to maximize their lives. Biomedicalization creates what Clarke, et al. term technoscientific identities, allowing people to “attain a previously unavailable but highly desired social identity. For example, infertility treatments allow one to become a ‘mother’ or ‘father,’ while the identity of ‘infertile’ can be strategically taken on by lesbians and single women to achieve pregnancy through technoscientific means” (81). However, who is allowed to pursue, who is encouraged to pursue, and who is given access to the technoscientific pursuit of the identity of “mother” or “father” can be seen through the scope of biopower.

Foucault’s ideas of biopower and biopolitics are a means of thinking about the change from sovereign power to a new form of power based on biology and (self) surveillance, biopower. In sovereign power, Foucault argues, the king held the right to "let live" and "make die;" now, he says, we police ourselves through governmentality and technologies of self in order to, for ourselves and others, "make live" and "let die" (241-5). Subjects are regularized and normalized based on these ideas of biology and biomedicine. So while (bio)medicalization is the intervention of medicine into the body, biopower allows us to consider how that medicalized individual body polices itself through surveillance in order to conform to society’s expectations of a functioning machine (technologies of self and anatomo-politics) and how the larger social body dictates the body of the subject (governmentality and biopolitics). And so, in considering biopower, or the organization of the population through bios, we can see the workings of biomedicine and biomedicalization (and of course the on-going medicalization).
First, we are expected to make ourselves and others live (biopolitics). Next we are expected to utilize and trust forms of biomedicine in order to make ourselves live (biomedicine). Finally, we are expected to embrace technological interventions into our bodies in order to lower the risk of illness (biomedicalization). If biopower argues that we now “make live” and “let die,” we have to consider who is made to live, who is allowed to die, and how exceptionalism and the ability to navigate the market ultimately determine both (Stratified biomedicalization is a term used by Clarke, et al. to describe these increasingly co-optative and exclusionary practices. (61)).

But rather than considering the exclusionary aspects of biopower in depth, in Chapter One of this project, I will investigate the role of biomedicalization in new reproductive technologies. Women have been historically associated with the body rather than the mind (Rapp 468); thus, the biomedicalization of society is particularly important to feminist studies and to this investigation of new reproductive technologies. Rayna Rapp explains, “[…] [T]he profound influence of biomedical discourses and practices on the production of gender was ripe for social analysis, as well. Thus, feminist scholars trained their sights on biomedicine, where the study of the reproductive life cycle and, especially, the politics of reproduction came under energetic scrutiny” (468). Feminist theory has often taken up the issues of reproduction, which is why I argue that these new reproductive technologies should be of special concern to women (aside from the obvious sort of biological reasons). These technologies arose in the name of biopolitical enhancement, and while they are often considered and marketed as giving women freedom over their reproductive choices, they merely create a biopolitical compulsion to procreate. What sorts of subjectivities are created through the implementation of new reproductive technologies and what sort of bodily discipline is required to be a “good” biopolitical subject?
So, biomedicine brings about biomedicalization, and biopower allows us to see how we are organized into who is worthy and able to make themselves live and who is allowed to die because of institutional blockades, like privatized insurance, corporate-owned medicine, and staunch requirements for public medical care, that prevent some people from monitoring and treating their bodies, a requirement of biomedicalization. We can use the idea of stratified biomedicalization, or as Rayna Rapp terms it, “stratified reproduction,” to consider who is allowed access to the new subjectivities that technoscientific reproduction creates. Indeed, while I am arguing that women feel the compulsion not only to procreate but also, and more importantly, to enhance the future, not all women feel this compulsion. Some women are stigmatized for and encouraged to abstain from procreation.

Chapter Two will focus on genetic essentialism and how that contributes to the compulsion not only to procreate but also to genetically procreate. Furthermore, there is a hierarchy that accompanies genetic essentialism that adoption theorists have critiqued. While adoption is certainly one path toward parenthood, it lies somewhere between genetic reproduction and childlessness (whether by choice or circumstance). The critiques of genetic essentialism that theorists like Charlotte Witt offer shed light on the morality judgments that childless and childfree women encounter. Since technoscience has granted us the ability to acquire subjectivities previously out of reach, there is more pressure for a woman to subject herself to medical intervention in order to genetically reproduce.

A discussion of reproduction and morality would be incomplete without an investigation of abortion. In light of the reasons presented above in favor of reproducing and the privileging of genetic connections, abortion can be seen as both immoral and unpatriotic. Abortion, however, is women using technoscience in an unanticipated way in order to eschew normative morality.
judgments and control their own bodies and reproductive choices. But if women are claiming private ownership of their own bodies (perhaps refusing medicalization in order to procreate or accepting medicalization in order to end a pregnancy), what sort of issues arise when women claim the bodies of other, usually marginalized, women for their own genetic reproductive aims?

To conclude this project, I will consider U.S. exceptionalism, how this has influenced compulsory procreativity, especially as it may apply to surrogacy, and how we can look to queer theory to displace and critique the value of the child. Contemporary U.S. society is organized through an orientation toward the future, through reproductive futurity. Lee Edelman in his book *No Future* asks us to consider precisely what society would look like without an orientation toward the future. Edelman investigates the construction of reproductive futurity, the figure of the Child (capital c), and the death drive. Using political examples, Lacan, film, and literature, he questions the collective, universal politics of reproductive futurism and our construction of the future. While he effectively disengages from feminist theory later I will posit ways in which feminist theory can eschew its focus of reproductive futurity and motherhood in favor of the queer negativity that Edelman considers.

While women may be figured as biopolitically responsible for enhancing the future, using Lee Edelman’s polemic in *No Future*, I suggest that there is a possibility for women to counter-identify with the “mother” subjectivity. Society, having changed from being organized through sovereign power to biopower, encourages subjects to police their bodies in order not only to fit a normative standard of health but also to make themselves live for as long as possible. While the imperative to “make live” is certainly an uneven one, considering race and class, the biomedicalization that has arisen from biopower is felt by all. The discourse of risk has been taken further than simply encouraging the reduction of risk in order to make people live longer.
Now, there is a desire to create low-risk subjects through technoscience. At the heart of this biomedicalization is the female body. Women inevitably bear the burden of enhancing the future through allowing technoscientific intervention in their bodies and through their “choice” of the “right” genetics. And so I will suggest queered childless women counter-identify with the subjectivity of “mother,” in order to alter the biopolitical imperative to enhance the future and in order to subvert the patriarchy that privileges the Child as emblematic of futurity and that for so long has reduced the role of women to formless wombs.

CHAPTER ONE

Feminist theorists once thought that assisted reproductive technologies would promote equality amongst the sexes by freeing women from the burden of childbearing. Before addressing the biomedicalization of the female body with regard to reproductive capacity, I will first consider the valuation of children in contemporary U.S. society. During the mid-nineteenth century, a cultural shift occurred in the U.S., creating a child-centered society that has influenced the contemporary practices and policies that regulate the female body and female autonomy. This focus on the child, I think, has contributed to the proliferation of pronatalism that encourages women to genetically reproduce and to submit to biomedicalization in the name of genetic reproduction. Following my consideration of this child-centered society and what it means for women, I will then analyze the increasing medicalization of fertility treatments. These two things together contribute to the idealization of motherhood, which impacts all women in some way regardless of age, race, and socioeconomic status. To finish this chapter, I’d like to argue that the stigma of childlessness is a result of compulsory procreativity.
The Myth of Childhood

Shulamith Firestone famously argued in *The Dialectic of Sex: The Case for Feminist Revolution* that advancements in technology would free women from “the tyranny of reproduction” (213). Firestone looked forward to a time when the burden of childbearing and childrearing would be equally shared between men and women. She argued that the (heteronormative) biological family construction was at the root of women’s societal oppression and that overcoming that oppression would require a revolution, similar to that of a Marxian proletariat revolution. Firestone’s arguments for what would later be termed new reproductive technology (NRT) have shaped feminist theory in a way that generally favors NRTS as empowering for women. In recent years, much work has been done to examine the effect of NRTS on feminist theory and thought, and such work is at the heart of my own project. However, before investigating further how assisted reproductive technologies have (and are) affecting female subjectivities, I will examine a shift in U.S. culture toward a valuation of the child and childhood.

An oft-overlooked portion of Firestone’s work is her chapter on childhood, in which she historicizes the “myth” of childhood and its effect on the social positioning of women. By calling childhood a myth in the fourth chapter of *The Dialectic of Sex*, Firestone (and other scholars that followed) meant that childhood as we know it today is a social construction, used to position children as inferior dependents. She asserts that the link between women and children results in a shared oppression. While her work is about the liberation of women from patriarchal oppression, Firestone contends that the liberation of women is also dependent upon the liberation of children (65). Firestone points out that “[i]n the Middle Ages there was no such thing as childhood. The
medieval view of children was profoundly different from ours” (68). The word ours in Firestone’s last statement still rings true nearly forty years later; children were not distinguished from adults. She traces the development of childhood to just after the fourteenth century, with the trending development of a language to describe and distinguish children from adults and the creation of children’s toys. Firestone writes, “Much was made of children’s purity and ‘innocence’. People began to worry about their exposure to vice. ‘Respect’ for children, as for women, unknown before the sixteenth century, when they were still part of the larger society, became necessary now that they formed a clear-cut oppressed bourgeois family, child-centered, entailed constant supervision; all earlier independence was abolished” (71). Society began to implement structures that prolonged childhood, like modern schooling. In expanding the time that it takes for a child to reach adulthood, a new system had to be implemented within the families to accommodate for the non-adult in the home, which is why Firestone argues that the oppression of women and children is a shared oppression. She explains, “The rise of the modern nuclear family, with its adjunct ‘childhood’, tightened the noose around the already economically dependent group by extending and reinforcing what had been only a brief dependence, by the usual means: the development of a special ideology, of a special indigenous life style, language, dress, mannerisms, etc. And with the increase and exaggeration of children’s dependence, woman’s bondage to motherhood was also extended to its limits. Their oppression began to reinforce one another” (Firestone 81, emphasis mine). While Firestone does an excellent job in making her point about shared oppression, it is also important to examine the Industrial Revolution as a time when children went from productive members of society to protected citizens.
For an analysis of this shift, I turn now to Viviana Zelizer’s *Pricing the Priceless Child: The Changing Social Value of Children*, in which she elucidates the transformation in the U.S. to a child-centered society. Like Firestone, Zelizer marks the valuation of the nuclear family and education as the beginning of the shift toward, what she terms, the “economically ‘worthless’ but emotionally ‘priceless’ child” (3). Zelizer’s argument hinges on the controversy of child labor and child labor laws, issues that started in the 1870s following the U.S. Industrial Revolution (57). “The child labor conflict is a key to understanding the profound transformation in the economic and sentimental value of children in the early twentieth century. […] New boundaries emerged, differentiating legitimate from illegitimate forms of economic participation by children,” Zelizer explains (57-8). While industrial work offered new employment opportunities for children, middle-class reformers argued that child employment was exploited labor. However, morality was not necessarily the reason for a reduction (and near-eradication) of child labor. Zelizer names two causes for this shift: the rise in demand for skilled and educated workers and the rise in income. Skilled workers took the place of children in the workplace, and with the increasing incomes families could afford to keep their children at home and in school. These conditions created the new norm nuclear family consisting of the male breadwinner, female homemaker, and schoolchild(ren). And so, in creating the emotionally priceless child, society exalted the male role and reduced women and children to dependents. Firestone also compares this supposed inferiority of children with that of women, who were similarly viewed as inferior beings in need of care.
Assisted Reproductive Technologies and Biomedicalization

Infertility is a term that has replaced the pejorative term sterility. Laura Mamo explains, “Sterility was defined as an inability to conceive due either to ‘natural’ circumstances such as one’s age and length of marriage or to more personal matters such as one’s mental, moral, and sexual habits” (25). In the increasing medicalization of fertility treatments, what Mamo calls childlessness has been “recast as biological pathology, rather than as moral degeneracy” (25). Sterility, she writes, “was viewed primarily as a social or moral issue, not as a medical problem requiring treatment” (25). (Childlessness as a moral issue will be something I address in the next chapter.) Artificial insemination, wherein sperm is injected into the uterus often by means of a needle-less syringe, was a practice that required no medical examination or evaluation. However, scientific research in the menstrual cycle, spermatozoa, and anovulation (the inability to ovulate) contributed to the medicalization of infertility (Mamo 28).

In 1978, the first-ever “test-tube” baby was born; in vitro fertilization (IVF) seemed to be a step forward in feminism (Mamo 31). Firestone, just eight years before, envisioned a future in which women would be free of the burden of gestation through the creation of artificial wombs, and IVF seemed like a move toward such equality. However, as Sarah Franklin points out in “Revisiting Reprotech: Firestone and the Question of Technology,” a chapter in Further Adventures of The Dialectic of Sex edited by Mandy Merck and Stella Sandford, Firestone’s argument for new reproductive technologies is somewhat problematic for feminists theorists: “From one point of view, new reproductive technologies (NRTS) such as IVF represent an intensification of the exploitation of women via their reproductive capacity. […] Yet other feminists, in the tradition of the women’s health movement, have written feminist guidebooks to new reproductive technologies aimed at empowering women who use them” (Merck 47). While
IVF seemed to have the potential to liberate women from their traditionally gendered roles. I side with those feminists who view NRTS as further stratifying women based on their reproductive capacities.

Somewhere during the shift from sterility to infertility emerged a medical imperative to procreate. As Mamo writes,

The depiction of infertility as an illness facing large numbers of women and curable only by means of medical treatment was challenged by 1970s and 1980s feminism. Some feminists argued that infertility practices represented another variant of pronatalism and constituted a backlash to women’s social, economic, and political advances. Infertility was interpreted as a consequence of a social imperative that encourages women to want children and to seek medical help (33).

While the question of what actually constitutes a woman’s “choice” is not new, it deserves consideration. The IVF procedure is expensive, intrusive, often painful, and has a very low success rate, even for those women who fall into the “low risk” category, that is, young women under the age of 40. Furthermore, women’s bodies, not men’s, are often exploited in the name of medical “treatment” for a so-called illness. In fact, women are being classified with the illness of infertility in order to receive care. Infertility is defined in heteronormative terms as “the inability to conceive after one year of timely, unprotected intercourse or to carry a live pregnancy to birth” (Mamo 32). Thus, lesbian women who wish to conceive must “prove” to doctors and insurance companies (masculine institutions) that they qualify as infertile in order to receive treatment.

While the feminist movement, especially the Second and Third Waves, fought for reproductive freedom – the freedom to choose when to have children – this reproductive freedom
seemed to bring with it pronatalism. The biomedicalization of infertility created compulsory procreativity, wherein the new biopolitics that accompany medicalization work to figure the childless and childfree woman as nonnormative, as queer. Even women who identify as LGBTQ and thus who do not conform to traditional ideals of compulsory heterosexuality can become complicit in compulsory procreativity. The driving force of this compulsion is undeniably gendered and has everything to do with womanhood.

If we define bearing children as a female biological act, we thus create a standard of womanhood. Mamo, citing Monique Wittig, writes, “the term woman is produced by, expressive of, and perpetuates (through its continued use) an economy of heterosexual relations. Since sex serves the economic needs of heterosexuality, Wittig argues, a lesbian is not a woman […]” (49). While this is certainly a problematic argument since the reiterative and gendered power of the word woman is seemingly impossible to escape, Mamo’s application of this assessment of lesbian as non-woman is useful to consider how compulsory procreativity works on all women, even those in relationships wherein they would be biologically incapable of genetic reproduction.

If a lesbian is not a woman in that she does not participate in compulsory heterosexuality, then assisted-reproduction technologies have the power to make her one by appropriating compulsory heterosexuality (Rich 1980) and repackaging it as compulsory reproduction.

In other words, if the “lesbian” procreates, does she then become a woman? (Mamo 49). Before assuming that women are choosing to bear children because of a biological compulsion, we must consider such gendered biopolitical pressures. Childbearing is by no means an avenue that all women can take to achieve womanhood. Indeed some women are pathologized for their procreation.
This double standard is what Dorothy Roberts addresses in *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. Roberts traces through history the abuse of the black female body in the United States, from slavery to now, in order to rethink issues of reproductive liberty as it relates to race. Roberts writes, “In contrast to the account of American women’s increasing control over their reproductive decisions, centered on the right to an abortion, this book describes a long experience of dehumanizing attempts to control Black women’s reproductive lives. The systematic, institutionalized denial of reproductive freedom has uniquely marked Black women’s history in America” (4). As I stated in the Introduction of this project and will investigate further in Chapter Two, reproduction has been tied to morality. For black women in the U.S., reproduction has been fraught with contradictions. While on the one hand, reproduction is viewed as a moral good and often as a civic obligation, black women in America have been disenfranchised citizens whose procreative powers and progeny have been met with disdain. If reproduction, especially in light of new reproductive technologies, is meant to *enhance* the future, then the regulation of black women’s reproduction implies that their role in society is less valued and viewed as destructive to society’s moral fabric. As Roberts reports, White childbearing is generally thought to be a beneficial activity: it brings personal joy and allows the nation to flourish. Black reproduction, on the other hand, is treated as a form of *degeneracy*. Black mothers are seen to corrupt the reproduction process at every stage. Black mothers, it is believed, transmit inferior physical traits to the product of conception through their genes. They damage their babies in the womb through their bad habits during pregnancy. They impart a deviant lifestyle to their children through their example. This damaging behavior on the part of Black mothers – not arrangements of power – explains the persistence of Black poverty and marginality. Thus it warrants strict
measures to control Black women’s childbearing rather than wasting resources on useless social programs (9, emphasis in original).

Roberts’ biting, tongue-in-cheek critique of how black motherhood is treated in the U.S. points toward issues of privacy and the female body. Like the example I give (using Elizabeth Kolbert’s article) in the introduction, genetic enhancement of the future leads to social enhancement of the populous, which is why procreation has not (and will likely never be) simply a private decision.

Roberts’ work is incredibly important to historicize the situation of black women in contemporary U.S. society. Rather than repeat her work here, I will move now to her consideration of compulsory sterilization, which would seem in opposition to my ideas of compulsory procreativity. Most women now are familiar with multiple methods and contraptions used for birth control (e.g., the Pill, diaphragms, intrauterine devices, etc.). Margaret Sanger, a nurse, advocate of birth control during the late nineteenth century, and founder of Planned Parenthood, coined the term “birth control”. At a time when contraception of any sort was illegal in many places in the U.S., Sanger argued that women should be able to control their own reproductive health and should not have to bear the burden of unwanted pregnancies (or self-induced abortions) (Roberts 57). Sanger’s movement did not garner much support from women, who were protecting their Victorian images. However, with the rise of the eugenics movement in the U.S. came support for birth control.

The eugenics movement in the U.S. came at a time when the immigration population was growing; the arguments of degeneracy used against black procreation were the same used against all non-white reproduction. Eugenicists claimed to desire the improvement of society; they “encouraged the breeding of superior citizens and voluntary cooperation in forming the most desirable unions. […] The movement’s most lasting legacy is its coercive enforcement of
negative eugenics, which aimed to prevent socially undesirable people from procreating. Eugenicists advocated compulsory sterilization to improve society by eliminating its ‘socially inadequate’ members” (Roberts 65). In addition to sterilization for the sake of racial cleansing, which itself was implicit, compulsory sterilization was implemented to “treat” women’s sexual promiscuity; these women were labeled “feebleminded” and admitted to state institutions for the purpose of sterilization. Roberts sums this up as, “In short, eugenic sterilization enforced social judgments cloaked in scientific terms” (70). Sterilization, one form of birth control, was used as a means of punishment for moral wrongdoings rather than as liberation for women.

Margaret Sanger, following World War I, allied herself with eugenicists in order to garner support for birth control, to prove that birth control could be useful to the nation. Sanger organized clinics aimed at reducing “the birthrates of their socially inadequate patients. The eugenics movement, in turn, supported Sanger’s birth control clinics as a means of reaching groups whose high fertility rates were thought to threaten the nation’s racial stock and culture” (Roberts 75). Sanger targeted Black Americans in her proposal for a “Negro Project,” which suggested opening facilities in black populated areas in an attempt to control their “breeding.” It should also be noted that W.E.B. Du Bois famously “chastised the birth control movement for failing to address the needs of Black people” (Roberts 77). While opening facilities for eugenic purposes served to further stigmatize the Black American population, these clinics did also provide health care and birth control to an otherwise marginalized and neglected community of people. My purpose in investigating compulsory sterilization, which lasted from 1929 to 1941, is to shed light on an often-overlooked time in U.S. history that has affected greatly American political discourse. More than valuing the lives of white women and children more, institutions were systematically eliminating an entire race of people based on skin color and supposed
degeneracy. And despite the eugenic undertones of Sanger’s movement, black women still desired access to birth control because they were called upon to improve the lives of the black community. In the late nineteenth century, “writers advocated birth control as a way for Blacks to reduce their dreadful maternal and infant death rates, ‘preserve their new economic independence,’ and improve their standard of living” (Roberts 84). The improvement of the black population following Emancipation rested firmly on the shoulders of black women, for it was their duty to control their reproduction. And so while it is true that not all women feel the compulsion to procreate in the same way, procreation is the means by which women are made to feel they will have the most effective contribution to a better future.

The Stigma of Childlessness

And so I argue that, despite racial difference, the norm of childbearing remains. Women are still expected to improve future generations by means of procreation, and though the terminology has ameliorated, the stigma has not. Mamo writes, “The medical classification of infertility has replaced that of sterility and thus destigmatized the state of being childless by shifting it from the realm of personal character to the realm of the biophysical” (30). I disagree. If this were true, women would no longer feel guilt for not wanting children; furthermore, they would feel no guilt for refusing to treat their “social” infertility, that is, “infertility” by choice. Feeling stigmatized is difficult to articulate, but to find their expression, I turned to online message boards. While there are, of course, caveats to using message boards rather than in-person interviews, the internet does allow for complete anonymity. And although this means that testimonials must be treated with some skepticism, their validity seems to increase since these user-provided testimonials are anonymous and unsolicited.
Within the “childfree” forums on the website Reddit, a site where users can submit and rate news, links, and messages, the user TokiDokiHaato asked on January 19, 2012, “Is Anyone Else Sick of Being Told They Will Change Their Mind?” This question elicited 100 votes “up” and only 6 votes “down.” One user’s answer to TokiDokiHaato’s question related clearly a scenario featuring the stigma of childlessness and the lengths to which she was expected to go in order to bear children. (I do, in fact, assume that this user is female based on the medicalization she would have to endure; her race is indiscernible since she does not expressly state it. Based on the encouragement she received to procreate one might assume, at one’s own risk, that she would be in a “normative” social position.) The user CowgirlInASpacesuit, hereafter Cowgirl, writes that she has been in a committed relationship. A few months into this relationship she became ill; her illness, which she never names, affects her fertility. She is told that when she is ready to conceive, she will need six months of fertility treatment in order to prepare her body for in vitro fertilization. She says, “I had tried it once for a couple months, but I couldn't handle it. My body went to crazytown. I cut treatments off early and was soooo much better once off. I was a wreck during the initial stages, but I have finally come to accept and make peace with the fact that I won't have kids. I am now perfectly happy with a future of being childless.”1 Although she expresses that she has accepted her decision to remain childless, I would argue that she has actually refused to subject her body to medicalization in the name of altering her reproductive system in order to bear children. However, her avoidance of medicalization and the acceptance thereof did not change the perceptions of those in her social circle. Cowgirl writes, “Telling others that I have made peace with the decision to not go through with the treatments and try for

1
http://www.reddit.com/r/childfree/comments/on1jk/is_anyone_else_sick_of_being_told_they_will/c3itf0m

23
kids has been harder than I thought. I figured that, especially after all I went through in my diagnosis and first round of treatments, people would be more understanding of my decision. It seems that, to some, babies need to happen by any means necessary.” Despite her desire to remain childless and her desire to avoid intense fertility treatments that caused her physical strife (“My body went to crazytown.”), she still feels that she is being judged for her unwillingness to conform to technoscientific norms of fertility treatment. She relates, “Yes, I have been looked down on for not wanting to go through 6 months of sheer mental and physical hell just to prep my body for the chance of an IVF to take. When I told my bf's [boyfriend’s] parents about my situation and decision, they simply told me that they would pay for fertility treatments. I'm not concerned about the financial costs. I'm worried about my health and the ability to be a good mom after months of torture well before a possible IVF pregnancy” (Ibid). Despite her articulation of her desire to remain childless and avoid intense medical treatment in hopes of getting pregnant, Cowgirl is assumed to be shirking her responsibility as a woman for selfish reasons – to save money and to save her own body.

Cowgirl would be considered “childfree” rather than “childless,” wherein the former denotes a decision to abstain from childbearing while the latter indicates a desire but an inability to bear children. Childfree women are often described as “selfish” for their decisions. In fact, “childlessness was often believed to denote a barren mind and body” (Mamo 25, emphasis mine). In February 2011 in a series of entries titled “No Kidding” for Bitch Media, the online version of Bitch magazine, writer/blogger Brittany Shoot shares her story of voluntary sterilization through tubal ligation and the stereotypes of childfree women. In her article “Why is It "Selfish" to Be Childfree?,” Shoot addresses the stereotype of selfish childfree women.

2 http://bitchmagazine.org/tag/no-kidding
Though her list is hardly exhaustive, she writes that childfree women are associated with two myths in particular – a) “You [Women] won't self-actualize without having a baby” and b) “Choosing your career over children is selfish. You [again, Women] could lose your job, but family is forever” (Ibid). Although Shoot critiques both of these claims, the user comments on the article reveal a more reductive and popular belief for the stereotype of selfish childless women – the pain of childbirth. Two users, Pixx and Jessica, both relate that they have been told by their mother-in-law and father respectively that not bearing children because of physical pain is selfish. Again we find that even “healthy” women without fertility troubles are expected to endure pain in order to bear children. And as Sarah Franklin writes, “If there is any take-home lesson from the literature on IVF or surrogacy it is that they are costly, painful and labor intensive procedures in which women are not less defined by sex but more so” (Merck 48). I would like to take that statement one step further to say that women are not only more defined by sex but also more defined by the medical status of their wombs – pregnant, infertile, childless. What women do and do not do with their bodies – and specifically with their wombs – is a public, social matter.

**Chapter Two**

Genetic essentialism is certainly at the heart of this project, which is why it was important for me to discuss in vitro fertilization in Chapter One. In this chapter, I will consider other options for motherhood: adoption and surrogacy. The two options are certainly valued differently in contemporary U.S. society, and I argue that genetic essentialism, coupled with compulsory procreativity, create this difference in value. While I argue in this project that increasingly
women are feeling pressure to bear children by any means necessary, the underlying issue is privacy and ownership of one’s own body. Kristin Luker addresses this issue of privacy in her thorough study of abortion, but I would like to think of privacy in the contemporary biomedicalized U.S. I will use Luker to consider how issues of privacy are changing for women while the expectation to procreate is continuously broadening. At work in compulsory procreativity is the belief that a woman’s duty is to procreate and also that the child is more valuable. Like Dorothy Roberts, Luker approaches the issue of reproduction (and abortion) through the legalities that are intertwined with the privacy of women’s bodies. But when women employ other women to bear their children through surrogacy, renting space in another woman’s wombs, how does this affect the boundaries of privacy for women? Firestone suggested that technological advancements and the ability to free oneself from the burden of childbearing would be one step toward gender equality. This chapter will investigate the stratification that is exaggerated through the valuation of biological essentialist reproduction over the privacy of women’s bodies.

**Adoption**

Adoption is one option that women (and men, for that matter) may take in order to achieve parenthood. However, for women the option of adoption brings with it certain stigmas that are not altogether dissimilar from the stigma of the childfree lifestyle. The stigma of both choices can be attributed to genetic essentialism. In *Adoption Matters: Philosophical and Feminist Essays*, a volume of essays edited by Sally Haslanger and Charlotte Witt, Witt’s chapter “Family Resemblances: Adoption, Personal Identity, and Genetic Essentialism” is about the socially constructed nature of genetic ties and the effect of these ties on adoptive families. Witt
writes, “In our culture, according to the standard view of the family, there must be a genetic tie among its members, even though the parents in the family are normally not biologically related to one another” (Haslanger 135). In her footnote, she writes that she is using the later twentieth century definition of the family; for my purposes, I’ll use the same. Witt points out that despite the existence of many “types” of families – blended, adoptive, step – the biological family receives the support of some pronatalist feminist theorists (Haslanger 136). Other theorists and legal scholars, however, are using the quickly evolving reproductive technologies to critique the biological family. Such a critique opens up a place for discourse about what constitutes a family, what constitutes the role of a mother, and how much value is being placed upon children in general and biological reproduction specifically.

Though my work is mainly about women seeking pregnancies (a delineation that Laura Mamo also makes in *Queering Reproduction*), it is import to consider those seeking parenthood. As I have stated previously, part of the stigma of childlessness (and the childfree lifestyle) is, apart from the assumption that one would want to reproduce at all, the expectation that one would prefer to reproduce biologically. And so for some women who have considered adoption or have successfully adopted, they have to work against a value system privileging genetics. Witt points out that much literature on adoption emphasized the importance of the birth/biological mother. She writes,

The biological view of the family that I have been discussing concerns primarily the role and superiority of biology in determining parenthood, or as the basis for parental rights. There is a second strand to the argument from biology concerning family, which concerns the role of biology in constituting personal identity. Genetic essentialism means that a person’s identity is determined by his or her genetic endowment (Haslanger 137).
Witt’s above statement is important because it addresses both the larger biopolitical social issue of genetic essentialism (creating a definition of the family that will serve a larger social purpose) and the more micro issue of personal identity, or technologies of self in Foucauldian terms. A genetic essentialist definition of family effectively creates a value system in which some are omitted and to which they will aspire. Witt begins her chapter by stating, “Recent developments in reproductive technology, increasing numbers of gay and lesbian parents, and growing numbers of families formed through adoption pose new questions concerning the definition the family and what families ought to look like” (Haslanger 135). Although Witt’s focus is on adoptive families, she references emerging reproductive technology and queer parenting in order to ground her critique in a more contemporary consideration of genetic essentialism. New reproductive technologies, like artificial insemination and in vitro fertilization, simultaneously give cause to question and also capitulate the normative, genetic definition of family.

On one hand, technoscience allows lesbians and women to achieve a subjectivity that they perhaps could not have previously attained. On the other hand, the use of technoscientific modes of reproduction have reinforced the genetic essentialism that Witt references. As Mamo argues, “[…] lesbian reproduction does not represent liberation from gender norms and the sexual and reproductive order, nor does it merely reinforce that order” (57). While lesbian reproduction has the potential to create a theoretical space for generative change, there is also a sense of queer capitulation to heteronormative ideals, of creating homonormative standards.

Homonormativity, as defined by Lisa Duggan, “… is a politics that does not contest dominant heteronormative assumptions and institutions but upholds and sustains them while

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3 To give a different example that is not necessarily related to reproduction, the Defense of Marriage Act (DOMA, 1996), which states marriage is defined as one man and one woman, also created a definition of the family that would serve to set a larger social standard to both police citizens legally and through self-surveillance.
promising the possibility of a demobilized gay constituency and a privatized, depoliticized gay culture anchored in domesticity and consumption.” (50). This definition seems to align well with my argument about queer reproduction. Though Laura Mamo explicitly disagrees with Duggan, claiming that queer reproduction subverts norms, I, like Duggan, argue that queer reproduction merely recasts heteronorms to accommodate LGBTQ subjectivities. To place this in a historical context, Laura Mamo points out that “during the twentieth century, a high value was placed on maintaining the opposite-sex, two-parent family as the dominant family unit (both symbolically and in actuality) and on sustaining the sanctity of marriage and importance of paternity as key aspects of family ideology” (57). And so, if the dominant heteronormative familial structure is “opposite-sex, two-parent family,” the homonormative familial structure will be a same-sex, two-parent family. Mamo, at times in her work, seems to allude to the potential for single-parent lesbian reproduction, which would indeed subvert the two-parent norm. However, for much of her study, Mamo refers in general to lesbian reproduction, much of which is indeed two-parent. In this way, Duggan’s definition of the homonormative rings true. Same-sex, two-parent families do not undo completely “dominant heteronormative assumptions and institutions”; despite the potential to shatter heteronorms, many choose to mimic heteronormativity, thereby creating hierarchies of difference within the LGBTQ community. To return to my discussion of adoption and genetic essentialism, there is a hierarchy present both within and outside of the queer community; there are those who adopt and those who undergo medical treatment to bear genetic progeny. As I discussed in the previous chapter, this stigma can be felt, lived, and sometimes articulated. However, for the purpose of this particular project on feminist theory and childlessness I will not investigate homonormativity further, though I think this debate of genetic

4 The tenets of, again, the Defense of Marriage Act of 1996 support Mamo’s claim here.
essentialism and homonormativity is a potentially productive one. Instead, I would like to consider a possible cause for the stigma women feel in relation to procreation.

**An Issue of Morality**

The issue of childbearing is a moral one when we consider the evolution of women’s rights to privacy. Such an evolution can be seen through the changes in technology and medicalization but can perhaps be most clearly seen in terms of abortion. Indeed, a discussion of childbearing and genetic essentialism without a consideration of the contentious topic of abortion would be incomplete. Though abortion is controversial, its controversy contributes to the way contemporary U.S. society values motherhood (and devalues the childfree). Laura Mamo also discusses the morality surrounding childbearing, but for a more thorough investigation, I will be using Kristin Luker’s work *Abortion and the Politics of Motherhood*.

Abortion was not always as socially charged as it is today. Luker points out that changes in technology cannot simply explain the shift from private decision to major political issue. “When the embryo⁵ was invisible, when pregnancy did not officially exist until the fifth or sixth month, when fertility was highly valued, and when abortion was unpleasant, dangerous, and often ineffective, there were few pressures to define the status of either the embryo or abortion,” she explains (5). Before the advent of ultrasounds and sonograms, there were no (or few) arguments over the personhood of the unborn child, and this issue of personhood is the current driving force of the abortion debate in the U.S. In fact, the blurred lines between medical practice

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⁵ Luker is careful to define her terms at the outset of her work. To avoid “choosing sides,” she attempts to demystify and depoliticize the language in her book. She writes, “In referring to the form of life that exists between conception and birth, to use either the word *fetus* or the word *baby* is to make a political judgment; in pursuit of neutrality, I will use the term *embryo*, even though it is technically inaccurate” (2).
and morality are at the heart of the abortion debate. Luker carefully traces this to the nineteenth century. As I discussed earlier, the Industrial Revolution caused many major shifts in the social and cultural organization of the United States. The U.S. saw changes in technology as well as population. In the move from agriculture to industry, there was also an increase in immigration, rousing anxiety about demographics (and miscegenation). Luker notes, “The intricate relationships between social roles, moral values, and medical technologies that were associated with changing medical patterns of fertility simultaneously become both the cause and the product of demographic strains […]” (15). Physicians, seeking to distinguish themselves as legitimate, savvy professionals, were at the center of the conflation of medicine and morality. Nineteenth century physicians argued that “they were compelled to address the abortion question because American women were committing a moral crime based on ignorance about the proper value of embryonic life […] and that] they were obliged to act in order to save women from their own ignorance because only physicians were in possession of new scientific evidence which demonstrated beyond a shadow of a doubt that the embryo was a child from conception onward” (Luker 21, emphasis mine). Ignoring the nineteenth-century sexism of the argument, Luker demonstrates that the physicians linked female fertility to both morality and technology, using their privileged institutional positions to police the actions of women. Physicians “shifted the focus of the [abortion] debate from moral values to empirical facts” (Luker 26). While I agree that a shift certainly occurs, moral values are certainly still implicated in the deployment of so-called facts. I stated earlier that nineteenth-century physicians sought validation of their profession; in choosing abortion as the platform for their campaign, physicians blurred the line that supposedly separated moral choice and medical practice.
The issue of professional control is important when we consider the fact that physicians (and others in the medical field) have positioned themselves as the authority of biological debates, which also have moral implications. Physicians maintained their right to be the leading voice in the abortion debate but for their own means; as Luker reports, they used abortion as a means of symbolically distinguishing themselves as superior to others who claimed to be healers.

By becoming visible activists on an issue such as abortion, [physicians] could claim both moral stature (as a high-minded, self-regulating group of professionals) and technical expertise (derived from their superior training). Therefore, the physicians’ choice of abortion as the focus of their moral crusade was carefully calculated. Abortion, and only abortion, could enable them to make symbolic claims about their status (31, emphasis in original).

The physicians of the nineteenth century convinced the public that abortion was both a moral issue of murder and an issue that needed, above all, medical judgment and intervention. To confuse matters, physicians maintained that abortions could, should, and would be performed in a medical setting where they could be monitored (both morally and technologically) (Luker 39). This history of the physician’s role in society’s perception of abortion is key to understanding the ways in which women’s bodies have been biopolitically controlled.

The moral-medical claim that physicians made about abortion has (and still does) affect public policy and women’s rights. What would seem for some to be a personal choice is for others an issue of morality that can affect (and infect) the well being of the nation-state. “In short, when abortion began to lose its status as a technical medical issue because of changes in the nature of medical practice, the institutional position of the Catholic church encouraged consideration of it as a moral issue,” writes Luker (62, emphasis mine). I maintain that it had
always been an issue of morality; Luker points to specific Catholic teachings that mandated punishments for those women who committed (what the Church considered to be) murder through abortion procurement. These theological rulings and teachings affected the perceptions people held about abortion, regardless of religious affiliation. What is important to consider here are the ways in which such institutional teachings have affected how we treat women’s bodies. Because women, as a sex, are able to bear children, their bodies and choices become public property and public interest; thus the choices that women make regarding their bodies (but mostly regarding their wombs) are fodder for public debate.

This issue of morality is one that haunts the subject of childbearing in general. Aside from the politically charged debate around abortion, I am arguing that women feel their morality is somehow linked to the decisions they make for themselves and their uteruses, and I have used the history of abortion to show this link of morality to what women do with their bodies. I have discussed in my consideration of adoption the hierarchy present in childrearing based on genetic essentialism. The choice to undergo medical treatment in order to reproduce is more than a desire to take part in a system that privileges biological, genetic procreation; it is a choice that is tied to morality. I argue that biopower works to police women toward the “moral” choice not only to bear children but to submit to medicalization in order to bear genetic children.

“Her Body, My Baby”

If childbearing is linked to morality, as I am arguing, perhaps this can account for the use of surrogacy to bear genetic children, which can allow women to become pregnant vicariously through another woman’s body. While surrogacy has been and can be a non-technical procedure, biomedicalization brought about a more technoscientific version of surrogacy. Today, using in
vitro fertilization, a woman’s egg can be fertilized outside of her body and then transplanted into either her own body or into the body of another woman, of a surrogate. Jacqueline Stevens, in the same volume as Charlotte Witt, writes about eliminating genetic privilege; with regard to terminology she prefers “genetic parent” to “biological parent,” a preference she bases on surrogacy and biomedicalization. She writes, “It is not biological narratives but specifically genetic ones that prompt women to want their own eggs, inseminated by their husbands’ sperm, to be carried by others. After all, what could be more ‘biological’ than carrying a fetus in one’s womb for nine months and then giving birth? Yet these are considered ‘surrogate’ and also not ‘real’ mothers. […] [W]hen procreation depends on technologies other than the penis and uterus, ‘natural’ is simply confusing” (Haslanger 70-1). Despite her privileging heteronormative marital kinship, Stevens makes an important point about the slippery terminology that has arisen from scientific innovation. Her focus is on the privileging that institutions give genetic parents over adoptive parents, but the same can, obviously, be applied to surrogacy. Stevens provides examples of studies that claim children are “‘at risk’ because they are not from households with two genetic parents” (Haslanger 78). What we can glean from such conclusions is the argument (using such studies as evidence) that genetic ties/reproduction should be privileged above all others; otherwise both adults and children become “risky.” Based on the risky nature of IVF and the contemporary desire to reduce risk, perhaps the desire for genetic connection contributes to women’s decision to bend to compulsory procreative pressures to submit to (often extreme) medicalization; perhaps for these women medical risk is worth it if it means avoiding becoming socially “risky.” But what if that medical risk were taken not by (or not only by) the biological mother but by another woman?
Like adoption, surrogacy involves extensive legal counsel and its own support community and vernacular. Surrogacy is the act of one woman carrying to term an embryo that belongs to someone else, usually in exchange for monetary payment. The woman who carries the embryo is the surrogate mother; the “owners” of the embryo are the “intended parents.”

Traditional surrogacy is usually achieved through artificial insemination, where the egg comes from the surrogate mother and the sperm from the intended father; the intended mother (usually and presumably the biological father’s partner) would then have to legally adopt the child from the surrogate mother. This procedure can lead (and has led to) complicated legalities and lawsuits over biological right versus financial, contractual agreements. With technoscience and new reproductive technologies, however, gestational surrogacy has become common. Gestational surrogacy is achieved through in vitro fertilization, wherein the egg(s) and sperm are donated from the intended parents, fertilized in a laboratory, and implanted into a surrogate. Aside from these two options, traditional and gestational, there are other permutations available if one were to choose surrogacy. A couple can have their fertilized egg (embryo) implanted into a surrogate. A woman can have her egg fertilized with donor sperm and then implanted. A person can request both donor eggs and donor sperm for implantation, which may seem like a strange choice since there would be no genetic ties to the intended parent. However, that final option seems to exemplify the importance of biomedicalization in contemporary society for a few reasons. It demonstrates that pregnancy itself can sometimes supersede the importance of genetic ties between parent and child. And if the desire to have genetic progeny is not the reason for using surrogacy, then perhaps the reason lies in a more biopolitical realm.

The title of this section and the inspiration for the title of this thesis project comes from an article published in the New York Times titled “Her Body, My Baby: My Adventures with a
Surrogate Mom.” In this lengthy article, Alex (Alexandra) Kuczynski recounts her personal experience with infertility and surrogacy, and she elucidates all of the points that I have made (and some that I have yet to make) in this project. Kuczynski undergoes years of intense medicalization, using fertility treatments and IVF in her attempts to get pregnant. She feels stigmatized both within her circle of friends and within the larger fabric of society; in some ways she herself perpetuates stigma through generalizations about other women. She expresses no interest in adoption, privileging a genetic connection above parenthood. Kuczynski experiences what she feels is akin to abortion. And, of course, Kuczynski employs a surrogate and participates in class-based exceptionalism. For this project, her story has it all; it exemplifies what it means to feel the burden of compulsory procreativity.

Kuczynski’s desire to be a mother, she says, has always been a part of her but she would not pursue this desire outside of a loving (and heterosexual) relationship (1). Once married, though, she found achieving pregnancy to be troublesome, and she decided to start the process of in vitro fertilization to fight what she terms “the battle for my fertility” (2). For Kuczynski, genetic progeny borne from the cells of both she and her husband was important. She writes, “Every I.V.F. cycle or brief blip of pregnancy offered the hope that I might soon be a mother, might seal the bonds of my marriage with a child, might soon be able to stopper the abyss of grief that threatened to suck me under every day” (4, emphasis mine). The child and motherhood for Kuczynski meant confirmation of her marital bond. She goes on,

The compulsion to create our own bloodline seemed medieval, and I knew we could enjoy our marriage — our lives — without a child. Yet I couldn’t argue myself out of my desire. A child with our genes would be a part of us. My husband’s face would be mirrored in our child’s face, proof that our love not only existed, but could be recreated.
beyond us. Die without having created a life, and die two deaths: the death of yourself, and the death of the immense opportunity that is a child (7, emphasis mine).

Indeed, to continue their bloodline was one lasting way Kuczynski felt she and her husband could affirm their love. On the other hand, though, to die without having reproduced genetically meant for Kuczynski the death of one’s subjectivity and potentiality. (Christine Overall, whom I discussed in the Introduction to this project, has an answer for this “death” of the potential child. She acknowledges the claim that a child never born is deprived of its own futurity; however, she notes that “nonexistent people have no moral standing” (78).) With this desire to affirm her own subjectivity and grant potential to her genetic progeny, Kuczynski felt it was necessary to subject herself to intense medicalization. Over the course of five years, she completed eleven cycles of IVF and had four failed pregnancies (4). The failed pregnancy that seemed most damaging for her and the one that she chooses to share in her article is that one that ended in what she felt to be analogous to abortion. When her doctor reports that Kuczynski is not, in fact, ten weeks along in her pregnancy, he recommends “a D and C, a dilation and curettage, the same procedure used in abortion” (3). Kuczynski’s own language begins to slip in her account of this experience, using “small dead baby,” “coagulation of cells,” “baby,” and “fetus,” to describe what had to be removed from her uterus (3). Knowing the gender (a girl) and learning that it had no genetic defects led to Kuczynski’s mourning of her potential child and of her feelings of failure, a sentiment she expresses a few times in her account.

What Kuczynski also expresses in her feelings of failure, aside from the inability to reach her goal of achieving pregnancy within her own body, is that she is feeling stigmatized. Visits to fertility clinics had an air of secrecy about them. During one visit, another patient compares their surroundings to an A.A. (Alcoholics Anonymous) meeting. She says, “We’re not supposed to
talk about who’s here. Your secret is safe with me” (2). Kuczynski also keeps her treatments a secret from her friends and family in an attempt to avoid unsolicited questions and suggestions, that were often personal and suggested that she was not policing herself enough or in the proper ways to achieve pregnancy (she drinks soy milk; she works too much; she spends to much time at the computer; she stresses too much) (2). And when Kuczynski finally does find a way to successfully create the genetic offspring that she desires, albeit via the womb of another woman, the stigma of her infertility does not disappear. She says, “Still, it was hard not to worry about what other people might think. Not being pregnant suddenly seemed like a public statement, one that left me feeling exposed and vulnerable” (7). She continues later, As much as I tried to fight off the feeling, when I told others that I was expecting a baby — and this child was clearly not coming out of my womb — I would sometimes feel barren, decrepit, desexualized, as if I were branded with a scarlet “I” for “Infertile.” At the height of her pregnancy, Cathy [the surrogate mother] and I embodied several facets of femininity. She could be seen as the fertile, glowing mother-to-be as well as the hemorrhoidal, flatulent, lumpen pregnant woman. I could be the erotic, perennially sensual nullipara, the childbirth virgin, and yet I was also the dried-up crone with a uterus full of twigs. She got rosy cheeks and huge, shiny stretch marks. I went to Bikram yoga and was embarrassed to tell the receptionist — in front of the pregnant 20-something yogini in short shorts — to pull me out of class in case my baby was about to be born out of another woman’s body (12).

Technoscience has made it possible for women to conceive outside of their own bodies, but the corporeal nature and expectation of pregnancy remains. Despite being vicariously pregnant, Kuczynski still feels “barren” and publicly exposed. Furthermore, she still feels this stigma even
after willfully submitting to the prescribed invasive and emotionally trying fertility treatments. In other words, even when “with child,” Kuczynski feels queered, feels as though she exists outside of the normative social structure.

However, I must also point out the exceptionalism with which she is complicit and which creates further stratification amongst women. Kuczynski and her husband used a lawyer to find a surrogate. She describes this as a business transaction, in which she and her husband browse potential surrogates, subjectively evaluate them, and rent one. She writes, “We were not disturbed by the commercial aspect of surrogacy. A woman going through the risks of labor for another family clearly deserves to be paid. To me, imagining someone pregnant with the embryo produced by my egg and my husband’s sperm felt more similar to organ donation, or I guess more accurately, organ rental. That was something I could live with” (6). Although she claims she was not bothered by the commercial nature of the transaction, both she and her lawyer were adamant about only considering women who were not living in poverty because poor women “are less likely to be in stable relationships, in good health and of appropriate weight” (Kuczynski 6). While she notes that none of the surrogates she considered had household incomes above $50,000, Kuczynski also observes that the surrogacy fee of $25,000 “would make a significant difference in their lives” (6). Furthermore, while she herself suffered physically and emotionally through the turmoil of her fertility treatment, after deciding to employ a surrogate Kuczynski nonchalantly says, “reproductive technology could make it relatively easy for us [she and her husband] to have our biological child” (7, emphasis mine). On one hand, she feels queered by her infertility; on the other hand, though, she feels superior and savior-like based on her socio-economic (and racial) privilege within the U.S.
Alex Kuczynski chose (employed) Cathy as her surrogate for several reasons, all of which have an air of social privilege. First, Cathy’s application was typed on a computer, and Kuczynski condescendingly remarks, “she [Cathy] must live in a house with a computer and know how to use it” (7). Cathy also claimed that monetary gain was not her main motivation, despite having two children enrolled in college and a household income of $50,000 or less. She claimed to be providing her services (her womb) for altruistic reasons. In addition to Cathy’s self-reported altruism, Kuczynski was also drawn to Cathy because she and her husband were college educated and did not seem completely dissimilar from Kuczynski and her husband (7).

Kuczynski writes, “Strictly speaking, she was a vessel, the carrier, the biological baby sitter, for my baby, or as she put it in her essay, ‘I will serve as the ‘foster mother’ to the baby until it is born.’ But it was easy to think of her as carrying my baby. She wasn’t desperate for the money, so our relationship wouldn’t have to feel like a purely commercial enterprise, or a charitable one. The only major factors separating us were the fact that Cathy could have a baby and I could not — and we had that $25,000 at hand” (7). Kuczynski calls this a “gentle hypocrisy” that allows the work of surrogacy to continue; if the intended parents did not believe their surrogate had altruistic aims and if the surrogate did not believe herself to be helping “disenfranchised” women/couples, then they would all have to admit that they were putting a price on the life of a child.

In the time before Cathy delivered the baby, Kuczynski engaged in a few other hypocrisies. Cathy was carrying a fetus belonging to Kuczynski, and although only the fetus “belonged” to Kuczynski, Alex began to feel ownership over Cathy’s body. When Cathy tells Alex that she is taking a trip to Las Vegas to attend a conference with her husband, Kuczynski considers asking her not to go. Kuczynski reports, “I took the news badly. My tiny child — now
that there was a sex, an identity, I could think of him as a child — was out there in Vegas at a craps table. I worried about the flight and whether the pressure would harm him. The thought crossed my mind to ask Cathy if it was really necessary to go, but I knew I couldn’t” (9). Later, when she realizes the experiences and luxuries that she can experience because, unlike Cathy, she is not physically pregnant, Kuczynski says she “was happy to exploit my last few months of nonmotherhood by white-water rafting down Level 10 rapids on the Colorado River, racing down a mountain at 60 miles per hour at ski-racing camp, drinking bourbon and going to the Super Bowl” (11). Kuczynski had successfully outsourced the physical pain of the genetic pregnancy she so desperately sought for five years. Describing her feelings, Kuczynski describes Cathy’s burden as a “gift,” saying, “I had been through so much — so much death and sorrow — that the gift of Cathy carrying my baby, shouldering the burden of the pregnancy, transferring all the fear of failure to her shoulders, was liberating” (11). But once Kuczynski revels in her liberation and then receives the product she purchased, her son, Cathy’s body and her gift suddenly disappear. At the end of the article, Kuczynski reports that she questioned her decision to choose surrogacy. She concurs with her husband as he effectively erases Cathy from the narrative of their family life when he says to Kuczynski, “You gave birth to our baby,” he told me. ‘The doctors went in and took our baby out of you 10 months ago.’ He was casting back to the day the doctor removed my eggs. ‘It was like a C-section. They just went in and got him when he was very small. And now he is here, and as much a part of you as if he had come out of your body. Because he did come out of your body.’” And just like that, Cathy is not only used for womb rental but she is also erased, no longer necessary for (re)production and able to slip back into her socio-economic class.
While Kuczynski’s story is an important starting point for thinking about woman-to-woman relationships in surrogacy, the work of surrogacy is not confined within U.S. domestic borders. Surrogacy is a transnational business. The film Google Baby (2010), directed by Zippi Brand Frank, follows Doron, an Israeli entrepreneur starting his own surrogate reproductive business in which he employs U.S. egg donors and Indian surrogates to fulfill the reproductive demands of a global community, and follows Dr. Nayna Patel, director of a surrogate clinic in India that implants embryos, monitors pregnancies, and delivers the children of intended parents. After paying $140,000 for U.S. surrogacy services and speaking with friends who expressed the desire for children but cannot afford the expense, Doron decides to find a cheaper alternative to U.S. surrogacy services. He remarks that in the U.S. there are both medical and legal fees that increase the cost of the service and learns that outsourcing the actual act of surrogacy can decrease the overall cost. He views an advertisement for Dr. Patel’s clinic and travels to India to pitch his idea. He tells her, “And my idea was to take a clinic in the U.S., use their egg donors and do the fertilization over there, create the embryos, and then ship the embryos to India and have the surrogacy here.” Before allowing Doron to continue much further, Dr. Patel gives her requirements for her services. She says that she only works with couples that have one or no children and that she only accepts “genuine” cases, for which Doron asks for clarification. Patel remarks that infertility would have to be “medically genuinely indicated.” Much like the issues that homosexual couples have historically faced in the U.S., Dr. Patel seems to insinuate that she only works with heterosexual couples. Doron leaves her office but continues his entrepreneurial pursuits.

In the film, a 57-year-old (presumably Israeli) woman named Irit calls Doron desperately seeking his surrogate service. She describes herself as, “I am 57, divorced, no children. I went
through many fertility treatments with miscarriages, that ended in miscarriages. And now I want
some help. I want a child. I want a baby” (subtitles used for translation). Doron confirms that she
will require both donor egg and donor sperm, since she has no partner and has gone through
menopause. If Irit would have no genetic connection to the child born from this surrogate
pregnancy, which I have argued is the main motivation for surrogacy, why would she choose
surrogacy over adoption? Perhaps it is because her age would disqualify her for adoption. While
biopower (over sovereign power) has certainly changed the way society organizes citizens and
although a pregnant 57-year-old woman would be outside of the norm in many countries, Doron
expresses no qualms about accepting Irit as a patron. He says excitedly that she would be his first
57-year-old customer. And perhaps, she chose surrogacy as a means of customizing, to be frank,
her progeny.

Throughout the film, the audience watches as Doron visits customers to help them choose
their donors for surrogacy. He visits with a male homosexual couple, leaning over a laptop with
them as they browse the website for Egg Donation, Inc., a U.S.-based company that provides egg
donor profiles that are complete with physical descriptions, photos, and user-created video
introductions. The couple browse the women, laughingly pointing out that their perusal is like a
dating website. They critique the women’s appearances, remarking on dimples, lips, and noses.
At one point, one of them says, “I don’t want a blond. I want someone that reminds me of my
sister, of my mother so I feel like my genes are there at home.” Both of these men will be
donating sperm for the fertilization procedure in hopes of creating what they refer to as “twins,”
though biologically these embryos would be half-siblings. The interest in having a female donor
that looks like a relative seems strange since most heterosexual men who plan to genetically
reproduce would probably not choose a female that resembles their mother or sister. What this
choice speaks to, though, is the desire for family resemblance that Charlotte Witt discusses. The man wants no one to mistake that this child is not his own.

In addition to the people seeking surrogate services, *Google Baby* also follows a U.S. egg donor. Featured with her two children, Katherine Gayleon of Tennessee says in her introductory video on the website for Egg Donation, Inc., “I’m about 5 foot 10. I weigh 130 pounds. I have brown hair and green eyes. I’m tall and fairly athletic.” She is the favorite of the homosexual couple we see browsing the website in part because of the affection she shows her children. Katherine has donated her eggs once before, providing twenty-six eggs in one procedure. The film follows as she prepares for another donation, injecting herself with medication that controls her ovulation. Speaking to someone off camera, Katherine says she is being treated like a robot because “they” (the doctors) are controlling her reproductive system. By the end of the film we learn that in her second donation Katherine has donated another 30 eggs, about 20 of which will likely be considered viable for use in IVF.

For a moment I would like to consider the roles of men in surrogacy. In both the storylines of the egg donor and the surrogate mother, the husbands and families feature prominently. Katherine’s husband seems reluctant to be featured in the film, refusing to respond when Katherine speaks to him on camera and engrossing himself in his drywall work. As her husband remolds their home, Katherine tells the audience that they purchased their large home knowing both that they would remodel the house and that they would be receiving funds for her egg donation. (She expects to receive $8,500 for her second donation.) However, later the film shows Katherine and her husband preparing and shooting very expensive rifles they’ve purchased. Her husband, finally speaking, relates that each one cost hundreds of dollars; they
even have a handgun and a small rifle for their oldest daughter. Katherine remarks that “this” [the purchase and maintenance of the guns] is where most of their money went.

The family life scene is decidedly different in India. One of the surrogates named Diksha recently had a miscarriage during a job for Dr. Patel but seeks another job so that she can provide for her family. The film follows as she visits a fellow surrogate worker, who has recently purchased with her husband a new home using her payment from Dr. Patel’s clinic. Diksha stands in awe of their large home, and her male host proudly shows her the foldout sofa they purchased. He says that no matter if people disagree or not, women are unintelligent and only useful for reproduction. Perhaps such beliefs among Indian men are why Dr. Patel runs her clinic in what the filmmaker believes to be a feminist manner. In an interview with NPR’s Neal Conan, Zippi Brand Frank says

I was completely convinced that it's exploitation of women. And, you know, when you're looking at it from abroad or from telephone conversation, it seems to be the worst thing a woman can go through. But when I went there and I spent, like, three times, with doctor - three excursions, tree trips to India with Dr. Patel. And I learned her, you know, and I was very much intrigued by her feminist agenda behind it. And also the surrogate mothers, you know, you say - you might say these are only 5,000 or 6,000 U.S. dollar that she gets. But actually, for those women, it's a lot of money.

And also for them, it's a big decision in which they are doing it against their, you know, against their families or their big families. They just go and decide, okay, we - that's our last solution to improve our family life, to give education to our kids, or to build a house or something like that. And it's important enough for us in order to do that, even though it's a social taboo.
So, you know, we have to look at things from both perspectives. What might seem for us, from, you know, being away is a very hard thing to do, it might be for them as sort of a salvation, as well, for some couples (4, emphasis mine).⁶

For Frank, Patel is offering an empowering service for women that allows them to be the salvation for their families, providing housing and education through the service of their wombs. In the film, Patel negotiates with a couple. She tells them that because they are fulfilling a dream of a childless couple, that couple wants to help fulfill their dreams in return; the couple has offered to pay for the home of their surrogate. But, before Dr. Patel agrees to disperse this money to the couple, she says she has only one request: that the home be placed in the name of Vaishali, the woman providing the use of her womb for this childless couple. The husband seems to falter for only a moment and agrees to put the house in his wife’s name. In this way and from a feminist perspective, the film leaves the audience in a state of moral ambiguity. Exploitation lends itself to empowerment. But in terms of biomedicalization, it is important to take away from this film the extreme medical measures that women will undergo in order to reproduce and to feel empowered within their own homes and family structures. The suffering of women appears to be a global issue, but despite the similarities in their desire to play an active role in improving the standard of living for their families, these women are from categorically different standpoints. Cultural exceptionalism is obvious in the film, and it is the topic I will address as I conclude this project.

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⁶ This interview, both audio and text, can also be found online at http://www.npr.org/templates/story/story.php?storyId=127860111. “Google Baby’ Follows Birth Outsourced To India.” Talk of the Nation. NPR. 15 June 2010. Radio.
CONCLUSION

When I first began this project, I was ready to make the argument that new reproductive technologies were being used under the auspices of U.S. exceptionalism. While that is still certainly at work, as I will explain, I can hardly say that only the U.S. is engaging in exceptionalism. As we see in the film Google Baby, men and women from several different nations – England, Dubai, Israel, and the U.S. to name a few – utilize Dr. Patel’s surrogacy clinic. Globalization has changed the way business transactions take place, and, yes, surrogacy is a business transaction. A service and a product are exchanged for monetary payment. As Zippi Brand Frank points out in her NPR interview, “it's no more just an issue of countries. I mean, we're in a global economy, global market and you know, you can find your solution anywhere else for even for cheaper prices and that's globalization” (3). The boundaries of countries and the boundaries of bioethical guidelines have certainly been blurred in this new global economy that is fueled by internet interactions and transactions. But for women, I think this also means that the lines of oppression have also been blurred, and this is where we find exceptionalism.

Jasbir Puar in Terrorist Assemblages: Homonationalism in Queer Times examines the very complicated ways in which queer subjects can be used for larger purposes of the nation-state; in this way, queer subjects become both normative (accepted as part of the nation) and nonnormative (part of the nation yet queer). Puar writes,

Exceptionalism paradoxically signals distinction from (to be unlike, dissimilar) as well as excellence (imminence, superiority), suggesting a departure from yet mastery of linear technologies of progress. Exception refers both to the particular discourses that repetitively produce the United States as an exceptional nation-state and Giorgio
Agamben’s theorization of the sanctioned and naturalized disregard of the limits of state juridical and political power through times of state crisis, a “state of exception” that is used to justify the extreme measures of the state (3).

While Puar is writing primarily about the state crisis of the U.S. “war on terrorism,” as coined in the early 2000s following the 9/11 attacks, I think there is a way to use her argument to investigate globalization and surrogacy. Childless and childfree women are queer subjects; they fall outside the normative structure of society through their failure or refusal to procreate.

Although these subjects are queer within the confines of the state, they feel superior to outsiders because despite their queerness they are U.S. citizens; similarly, the U.S. will biopolitically stigmatize these subjects while still accepting them as exceptional citizens that serve the nation-state. “[E]xceptionalism gestures to narratives of excellence, excellent nationalism, a process whereby a national population comes to believe in its own superiority and its own singularity – ‘stuck,’ as Sara Ahmed would say, to various subjects,” Puar writes. Furthermore, she writes that feminism, usually a discursive space for potentially gaining an understanding of the oppression of different women, is not exempt from using exceptionalism. Using Inderpal Grewal in her argument, Puar writes,

Forms of U.S. gender and (hetero)sexual exceptionalism from purportedly progressive spaces have surfaced through feminist constructions of “other” women, especially via the composite of the “third world woman.” […] The United States routinely positions itself “as the site for authoritative condemnation” of human rights abuses elsewhere, ignoring such abuses within its borders. Grewal alludes to the American exceptionalism that is now requisite common sense for many feminists within U.S. public cultures: “Moral
superiority has become part of emergent global feminism, constructing American women as saviors and rescuers of the ‘oppressed woman’” (5).

This sort of feminist exceptionalism is precisely what we see in transnational surrogate transactions. In *Google Baby* in the scene where Dr. Patel negotiates with Vaishali and her husband to put their new home in the Vaishali’s name in order to receive the “extra” money the intended parents are offering, Patel says that the couple would like to help the surrogate family realize their dream of homeownership. The couple’s offer to buy a home for the surrogate’s family is motivated, as Puar and Grewal point out, by moral superiority and by a desire to “save” a third world family. Dr. Patel herself seems complicit in this feminist savior role, as she insists that she is helping this oppressed woman by making the surrogate and not the husband the homeowner. (And lest we forget, Patel is running a business. Speaking to Neal Conan, Frank reports that Patel at the time of filming employed 70 surrogates; as of July 2010, Patel employed more than 300 surrogates (3).) Zippi Brand Frank certainly seems to agree with a sort of feminist exceptionalism. Though it should be noted that English is not her first language, during her NPR interview, Frank says a few thousand dollars paid to the Indian surrogates “might be for them as sort of a salvation” (4). By salvation, Frank seems to refer to the social-class mobility that the money gained from surrogacy services can provide; in other words, these consumers save and empower the underprivileged, ethnic-racialized female subject by creating jobs and outsourcing (in a multitude of ways) labor. What this so-called-feminist exceptionalism creates is further class and race stratification amongst women. As Puar mentions, feminism is viewed as a progressive space; Third Wave feminism wanted to reify the differences between women instead of universalizing the female experience. And though surrogacy doesn’t universalize the female experience, it does not necessarily move feminism forward. By subjugating women in India and
claiming moral superiority, women are participating in the very same patriarchal, biopolitical
tstructure that has oppressed and queered their subjectivities. These childless women that seek
surrogate services are answering to compulsory procreativity. Even if the biological mother
herself cannot bear children, biomedicalization has given her a solution that she can use to take
on a normative subjectivity (i.e. a “mother”).

Since the abortion debate became part of the political rhetoric in the United States, the
decisions women make have been construed reductively as women exercising their right to
choose. I heartily disagree with such an assertion because unfortunately, this sort of logic works
only if the influence of patriarchy has been trounced, which it has not been. Are women choosing
to procreate even at the risk of their own health and even at the risk of another woman’s health?
The fact that childlessness and childfree lifestyles remain stigmatized, despite a proliferation of
web-based communities, speaks volumes. Consider especially the motivations for participating
in surrogacy. On one hand, I have argued that the shift in biomedicalization compels women to
procreate by any means necessary because technology allows them no “excuse” for their barren
wombs. On the other hand, the women’s stories presented in “Her Body, My Baby” and Google
Baby reveal the financial motivations of surrogacy: to buy a home, to contribute to the family
household, to educate one’s children. Technology compels these women to submit to
biomedicalization to produce not only their own progeny but also that of others. The surrogates
provide a service, and deliver a product. In this valuation of the product (a newborn), the body
and subjectivity of the surrogates disappear, a literal alienation of labor.

Exceptionalism can occur both domestically and transnationally; in the cases I have
presented in this project, women can ignore the suffering of other women in lower economic
social classes. In “Her Body, My Baby,” Alex Kuczynski is able to distance herself from the
suffering of Cathy, focusing on her own strife, and as I pointed out, Cathy disappears from the narrative completely by the end of Kuczynski’s account. In *Google Baby*, the suffering of the surrogates is ignored; the focus is on carrying to term a healthy fetus for paying customers. While some, like Dr. Nayna Patel, argue that the surrogates and the intended parents are easing the distress of each other, like an exchange, I must return to the point of compulsory procreation to say that we must question the motivations for procreation in the first place.

If women are choosing to procreate, then why is the choice to procreate exalted and the choice to remain childfree (or refrain from medicalization or partake in medicalization to abort an unwanted pregnancy) denigrated? Women are not simply choosing to procreate. They, perhaps, are choosing to bow to the dictates of contemporary compulsory procreativity; not only should a woman procreate but she should also seek to genetically enhance the future by subjecting herself to medicalization if necessary. More value, therefore, is placed on the child and on futurity. Despite the advancements in reproductive technology that Firestone theorized would aid in the eradication of woman as womb, the child is still more valued than the woman from which it comes (surrogate or otherwise).

**No Future**

There may be a solution, however, that can move feminism past this valuation of the child, or rather figure of the Child, as a symbol of reproductive futurity. In *No Future: Queer Theory and the Death Drive*, Lee Edelman begins with the example of President Bill Clinton’s participation in public service announcements for the Coalition for America’s Children in order to (re)gain popularity in the polls. While this move was “extrapolitical,” it was also “impossible to refuse … permit[ing] only one side” (1-2). How could anyone deny a fight for the children?
While there are surely many other examples, it is important that Edelman begins with a political (or, rather, extrapolitical) example. The crux of Edelman’s argument lies in the work of the political, of the populous, of biopolitics. He writes,

Politics insofar as the fantasy subtending the image of the Child invariably shapes the logic within which the political itself must be thought. That logic compels us, to the extent that we would register as politically responsible, to submit to the framing of political debate – and, indeed, of the political field – as defined by the terms of what this book describes as reproductive futurism: terms that impose an ideological limit on political discourse as such, preserving in the process the absolute privilege of heteronormativity by rendering unthinkable, by casting outside the political domain, the possibility of a queer resistance to this organizing principle of communal relations. (2, emphasis mine)

The compulsion that Edelman mentions is certainly a biopolitical one, wherein the figure of the Child as emblematic of the future and who is innocent and in need of protection and acculturation is reinforced as “good” on multiple levels of the social world. A fight for a (potentially brighter) future is therefore a fight for children and therefore a fight for heteronormativity. Conversely, the queer and queerness is that which lies in opposition to heteronormativity and therefore children and therefore futurity. This is where Edelman makes his stance for his use of the death drive.

While reproductive futurity is constructed as a biological instinct, Edelman argues, using Lacan, that the Child is the object around which the reproductive drive circulates. This drive by means of politics, both of the left and right, “works to affirm a structure, to authenticate social order, which it then intends to transmit to the future in the form of its inner Child” (3). In
opposition to this structure, we find queerness and the death drive: “a place, to be sure, of abjection expressed in the stigma, sometimes fatal, that follows from reading that figure literally, and hence a place from which liberal politics strives … to disassociate the queer” (3). The death drive, as controversial as it sounds, is not necessarily a drive for death, destruction, and annihilation; rather it stands in opposition to the heteronormative drive toward futurity. The definition of the death drive depends on Lacan’s *jouissance*; “sometimes translated as ‘enjoyment’ … *jouissance* evokes the death drive that always insists as the void in and of the subject, beyond its fantasy of self-realization, beyond the pleasure principle” (25). Edelman argues that we are in a constant state of repetition “that fixes identity through identification with the future of the social order” (25). Queerness, then, interrupts this repetition, marking a difference that is seen as a threat to reproductive futurity, to normativity, and thus to the social community. But while some theorists and activists insist that the queer is “just like anyone” else (read: just like a normative subject), Edelman suggests that we embrace this death drive with which the queer is associated. He writes, “By denying our identification with the negativity of this [death] drive, and hence our disidentification from the promise of futurity, those of us inhabiting the place of the queer may be able to cast off that queerness and enter the properly political sphere, but only by shifting the figural burden of queerness to someone else” (27). Queerness is necessary to affirm normative structures, and thus in assimilating to those normative structures by insisting that the queer subject is just like everyone else, the (stigma of) queerness is merely shifted. And so, the figure of the Child is an emblem for a futurity that is invested in heteronormativity; queer and queerness thus need not embrace this futurity but must rather embrace the negativity and death drive with which they are associated in order to disrupt the normativity which is used to oppress and stigmatize them and others.
Interestingly, in his polemic about the figure of the Child as emblematic of reproductive futurity, Lee Edelman effectively chooses to disengage with the figure of the mother, even when talking about the Pill and in vitro fertilization. First, when we discuss reproductive futurity, we must acknowledge the bodies in which this reproduction is expected to take place. Edelman mentions also that we should reject the call to nurture the Child so we must again acknowledge the bodies that are constructed as the site of nurturing. Thus the overarching female implications in reproductive futurity linger like a ghostly figure. If the future is figured in the Child as born out of normative heterosexuality, regardless of biotechnological innovations, then how could it not also be figured in the woman, from whose loins this figural Child should spring? While using Jean Baudrillard’s argument that technoscientific interventions have brought about liberation from reproduction, which has led to liberation from the act of sex itself, the question should logically arise of “liberation for whom?” While men may feel a certain amount of pressure with regard to the reproductive futurity that seeks to organize society (or around which society seeks to organize) and posterity/lineage, it is apparent from earlier sections of this project that women feel this pressure and this burden exponentially more than men. And furthermore, those women who reject or are unable to fulfill this burden are figured as queer. And yes, Edelman says that “queerness names the side of those not ‘fighting for the children,’ the side outside the consensus by which all politics confirms the absolute value of reproductive futurism” (3). But while this may seem inclusive, Edelman’s use of examples of queer white men (and in the final chapter, the example of birds) do not necessarily denote this inclusiveness. Women who do not answer the call to procreate are effectively refusing futurity and refusing their social, biopolitical responsibility to enhance the future. Edelman, in the tenth endnote for Chapter Three, notes that he chooses not to consider women in his analysis because doing so would create ineffective
subcategories and would need more qualifications to make his argument (113). I think it is apparent that there is a simple way to understand women’s role in reproductive futurity and their biopolitical responsibility and to consider how those who refuse the normative compulsion to procreate are queered in the sense of being figured as anti-Child, anti-futurity.

What I am suggesting for feminism, then, is a similar embracement of the death drive, a critique and denouncement of the value placed on futurity (on the Child). Exalting the value of the child creates a compulsion to enhance the future, and technoscience allows women to conform to that compulsion, regardless of their fertility status, creating a space to subjugate other women. Compulsory procreativity forces us to examine how new reproductive technologies have actually affected female subjectivity. These technologies, the same ones that Firestone suggested would help women revolt against patriarchy, have created new means of capitulating to normative structures. The choices of some women to remain childless are still stigmatized, and women are still bound to their reproductive capacities, even if they outsource the labor. Firestone proposed artificial wombs; what we have gotten instead are the wombs of socially and economically disenfranchised women. Rather than embracing biomedicalization and technoscientific advancements as creating choices and granting women autonomy over their bodies, we must acknowledge the social class and racial stratification that new reproductive technologies and globalization have created, both domestically and across transnational borders. Displacing the value of the Child and futurity is one way, I suggest, women can attempt to eschew compulsory procreativity.
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