Sexuality Research and Social Policy
https://doi.org/10.1007/s13178-024-01032-0

Perceived Impact of the Overturning of *Roe v. Wade* on Queer Parents' Reproductive and Sexual Lives

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Accepted: 27 August 2024

Abstract

Introduction The current mixed-methods study examined the perceived consequences of the *Dobbs* decision from the perspective of members of the LGBTQ + community (e.g., bisexual women partnered with men) who may be at elevated risk of unintended pregnancy. Little research has addressed the psychological experiences of and perceived consequences of the *Dobbs* decision, which eliminated the constitutional right to abortion, among LGBTQ + people. Our findings offer insights into how the decision impacts LGBTQ + peoples' sexual, reproductive, and parenting lives across the U.S.

Methods Using a mixed-methods online survey, data were collected from 99 LGBTQ + adults who were assigned female at birth (AFAB) and had at least one young child, in the spring of 2023. Data were analyzed using chi-square statistics and qualitative thematic analysis.

Results Findings revealed mostly negative reactions to the overturning of *Roe v. Wade*, concerns about reproductive and sexual healthcare, and perceived impacts of *Dobbs* on future plans (e.g., childbearing and where to live). Concerns were often heightened for those in abortion-hostile states compared to those in abortion-protected states. For example, participants in abortion-hostile states were significantly more worried about unintended pregnancy, access to contraception, access to reproductive and sexual healthcare providers, and access to in vitro fertilization.

Conclusions Guided by a structural stigma framework, we found that LGBTQ + people—located in both abortion-friendly and abortion-hostile states—offered a range of perspectives regarding their feelings about and perceived consequences of the *Dobbs* decision. Those who lived in more structurally stigmatizing contexts tended to voice more intense responses (e.g., terror).

Policy Implications Our findings hold implications for practitioners, policymakers, and researchers who work with LGBTQ + people and other marginalized groups who may be experiencing threats to their reproductive agency. Our participants' perspectives are illuminating and grant policymakers first-person accounts of the psychological experiences associated with national changes in abortion and reproductive health policy.

Keywords *Roe v. Wade* · Abortion rights · Structural stigma · Policy · LGBTQ + · Reproductive and sexual health · Mixed-methods research

The overturning of *Roe v. Wade*, in the case of *Dobbs v. Jackson Women's Health Organization*, has implications for people across the United States (U.S.). Such implications are more pronounced for individuals residing in states with oppressive abortion policies, and for individuals who are marginalized based on sexual orientation, gender identity, race, income, and other statuses. Indeed, research on the impacts of anti-abortion policies, activism, and rhetoric rarely includes LGBTQ + people even though anti-abortion rhetoric is tied to anti-LGBTQ + discourse and is part of a broader anti-feminist ideology that emphasizes "the family" and traditional gender roles as ideal (Nandagiri et al., 2020; Pavan, 2020).

Of interest in the current study is how queer people assigned female at birth (i.e., AFAB individuals and people with female reproductive systems), who are also new

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Published online: 17 September 2024

parents, experienced the overturning of *Roe*. This judicial decision occurred amidst the broader context of social and political upheaval in the U.S. that included, but was not limited to, intensifying anti-LGBTQ + legislation. Many of the same regions of the country that have enacted anti-LGBTQ + policies are also places where abortion access is most restrictive (Klein & Gruberg, 2023). We aim to capture, in particular, the experiences of bisexual women partnered with men—a large but often invisible segment of the LGBTQ + community, and one that is potentially at greater risk of health disparities within the larger pool of childbearing individuals (Kirubarajan et al., 2022). We focus on parents of young children to ensure that their early parenting experiences occurred within a similar sociopolitical climate, and because we hoped to understand the implications of *Dobbs* for their future childbearing decisions—which are more relevant to parents of young children given the tendency to space children no more than 4–5 years apart (Centers for Disease Control, 2023).

Our specific interest is in how structural stigma (i.e., conditions, norms, and policies that constrain stigmatized individuals' opportunities and well-being; Hatzenbuehler & Link, 2014), including structural violence in the form of restrictive abortion policies, is impacting queer AFAB individuals. Our investigation of such impacts is framed by an intersectional lens, whereby we consider participants' specific identities (e.g., sexual orientation, gender, race, and class) and geographical context, given that vulnerability to marginalization varies by social location and broader structural factors such as state policies. Our primary research question was: How do queer AFAB parents of young children (i.e., people who have given birth in the past several years of intensifying sociopolitical unrest) expect the overturning of *Roe* to impact them and their families? Insomuch as individuals' perceptions, fears, and concerns related to *Roe* are likely to vary based on their states' abortion laws, we included participants in states where abortion remained protected after *Roe* as well as participants in states in which abortion was restricted.

Literature Review

Dobbs v. Jackson Women's Health Organization

On June 24, 2022, the U.S. Supreme Court, in the case of *Dobbs v. Jackson Women's Health Organization*, ended constitutional protection for abortion rights, restricting reproductive healthcare access for millions of individuals across the U.S. who can become pregnant (Dobbs v. Jackson Women's Health Organization, 2022). The *Dobbs* decision set the groundwork for states to enact restrictions that eliminate abortion access, as well as to ensure protections that secured such access. Within three months of the decision, 13 U.S. states had enacted total bans on abortion (Kirstein et al., 2022); currently, 14 U.S. states ban abortion (New York Times, 2023). In seven states, abortion is highly restricted (that is, there are gestational limits—laws that prescribe the point in a pregnancy where termination is allowed versus disallowed; i.e., 6, 12, 15, or 18 weeks), and, in five states, bans were introduced but blocked or the legality of abortion is being disputed (New York Times, 2023). Individuals in states where abortion is illegal or restricted may now have to travel to states where abortion is legal to self-manage their abortion or give birth (Skuster & Moseson, 2022), a process that can be emotionally burdensome, creating stress and shame (Kimport & Rasidjan, 2023). But, not all individuals who want an abortion will be able to get one. The consequences of being denied a wanted abortion are well established and include an elevated risk of raising a child in poverty, staying in an abusive relationship, poorer child developmental outcomes, and unmet life goals (Foster et al., 2018a, 2018b).

The restrictions on abortion access inevitably affect people in the U.S. differently depending not only on where they live but also on their identities and social locations. Certain pregnant people—such as those who are marginalized on the basis of their gender identity, sexual orientation, class, and race—will be less likely to seek or secure a safe abortion (Cohen et al., 2022). In addition to affecting access to procedural, medication, and self-managed abortion, *Dobbs* will affect access to contraception and reproductive care, potentially worsening intersectional disparities in access to such care (Thornton & Arora, 2023).

Sexual Orientation and Gender Identity

The overturning of *Roe* has implications for lesbian, bisexual, and queer (LBQ) cisgender (cis) women as well as AFAB trans/nonbinary individuals (Cohen et al., 2022; Dawson & Leong, 2020; Wilson et al., 2021). For bisexual women ages 15–44, the odds of an unintended pregnancy are 1.75 times greater than that for heterosexual cis women (Everett et al., 2017). AFAB trans/nonbinary individuals have also been found to have elevated rates of unintended pregnancy (Reynolds & Charlton, 2022). Likewise, bisexual cis women are as many as three times as likely as heterosexual cis women to have abortions (Charlton, 2022; Charlton et al., 2020). Such elevated rates reflect, in part, lower levels of contraceptive use. Bisexual/queer women may be less likely to use contraceptives than their cis heterosexual peers (e.g., because of poor provider-patient communication), placing them at risk of unintended pregnancy and STIs (Porsch et al., 2020). AFAB trans/nonbinary people also show lower rates of contraception use than cis heterosexual women (Reynolds & Charlton, 2021). LGBTQ + people are

also at elevated risk of sexual violence, which may result in unintended pregnancy and/or abortion (Charlton, 2022). One study of abortion patients, for example, found that exposure to sexual violence was higher among LBQ cis women than heterosexual cis women (Jones et al., 2018).

Such elevated rates within subgroups of the queer community reflect gaps in sexual health education, which focuses on cis heterosexual people (Reynolds & Charlton, 2022). These risks also highlight broader disparities in access to healthcare for LGBTQ + people (Cohen et al., 2022), including sexual and reproductive healthcare—systems that are rooted in pervasive heterosexism such that LGBTQ + people's needs and experiences are ignored or stigmatized (Gessner et al., 2020). For example, LGBTQ + people are less likely to receive appropriate counseling around contraception (Charlton, 2022; Tabaac et al., 2022) and LBQ cis women and AFAB trans/nonbinary people are less likely than their cis heterosexual peers to undergo reproductive cancer screenings (Agénor et al., 2021; Peitzmeier et al., 2014). Poverty and rurality may magnify LGBTQ + people's reproductive health risks: LGBTQ + people are both more likely to reside in poverty and to live in rural areas than cis heterosexual people, limiting their access to adequate reproductive healthcare (Movement Advancement Project, 2019; Wilson et al., 2023).

Sexual health risks may be elevated for LBQ individuals in states characterized by higher levels of structural stigma (e.g., fewer protections for LGBTQ + people and fewer abortion providers). Charlton et al. (2019) found that LBQ young women living in states with higher levels of structural stigma were more likely to have an STI compared to those living in low structural stigma states. Poorer birthing outcomes (e.g., lower birth weight) have also been documented among sexual minority women in states with fewer LGB protective policies, compared to sexual minority women in states with more favorable policies (Everett et al., 2022).

Bisexual cis women's elevated risks in the areas of sexual and reproductive health are consistent with their disproportionate burden of mental and physical health challenges compared to both lesbian and heterosexual cis women (Bostwick et al., 2015; Smith & George, 2021). Such health disparities have been attributed to bisexual women's exposure to bisexual stigma (e.g., stereotypes about bisexual people) and bisexual invisibility (e.g., being "read" as heterosexual or lesbian; Flanders et al., 2016; Smith & George, 2021). Furthermore, LBQ women partnered with men may have poorer mental, sexual, and reproductive outcomes than LBQ women partnered with women (Dyar et al., 2014; Flanders et al., 2016; Januwalla et al., 2019). Higher rates of miscarriage and pregnancy complications (Januwalla et al., 2019) and postpartum depression (Flanders et al., 2016) have been observed in male-partnered bisexual women compared to female-partnered LBQ women. Yet while male-partnered bisexual women are a large proportion of childbearing sexual minority women (Ross et al., 2018), their relational context has often rendered them invisible in studies of sexual minority health and parenting. Researchers typically sample sexual minority parents based on relational context, not identity, resulting in samples of female couples with children—not bisexual parents (Goldberg et al., 2020). Bisexual women partnered with men occupy an important space whereby most conceive children in the context of their relationship, rendering issues of contraception, pregnancy, and abortion salient—but their sexual identities mark them as a marginalized, and invisible, population (Goldberg et al., 2020).

Income, Race, Employment, and Age

Other groups, beyond bisexual women, also show heightened sexual and reproductive risks. Lower-income women face barriers to reproductive and sexual healthcare, including reduced access to contraception and abortion (Mann et al., 2016; Mosley et al., 2022). Dickey et al. (2022) studied 18 post-abortion patients and found that access to abortions was shaped by poverty, structural inequality, and unstable partnerships. Lack of financial resources constrained women's reproductive autonomy and decision-making in that they did not feel confident in their ability to pursue either abortion or parenting. Many discussed how even if they struggled to find economic support to get an abortion, they persisted in obtaining one because they had inadequate support to keep a baby and, thus, had no alternative. The authors concluded that restricting and outlawing abortion care is detrimental to the well-being of pregnant people and their families by perpetuating cycles of poverty and deepening socioeconomic and racial/ethnic inequities.

Considerable research documents how restrictive abortion policies disproportionately impacts Black, unemployed, and younger people (Dickey et al., 2022; Mosley et al., 2022). Thus, in states where there are gestational limits associated with abortion access, such groups may be especially vulnerable to being denied an abortion and having to travel to access them. In a study of 41 Ohio residents who received abortion care in either Ohio or Pennsylvania, Odum et al. (2023) found that, given Ohio's 22-week gestational limit at the time of data collection, and because the cost of care increased over time, economic challenges were especially salient for their mostly low-income and Black sample. As Thornton and Arora (2023) note, the *Dobbs* decision will inevitably exacerbate structural barriers to reproductive autonomy, "particularly for low-income patients of color, and continue to perpetuate inequitable access to reproductive healthcare" (p. 2).

Theoretical Framework

This study is guided by a structural stigma framework, which defines structural stigma as "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized" (Hatzenbuehler & Link, 2014, p. 2). In this study, structural stigma encompasses the *Dobbs* decision and the resulting sociopolitical discourse. Further, as some scholars have noted, experiences and impacts of structural stigma may not be felt the same for all members of a minoritized group (Rao et al., 2020). Reproductive health disparities may be pronounced for certain members of the LGBTQ + community, such as those who are low income or of color (Charlton et al., 2019; Dawson & Leong, 2020).

Restrictive abortion laws and anti-abortion infrastructure (i.e., intersecting factors that obstruct abortion access, including financial insecurity) can be viewed as forms of not only structural stigma, but also structural violence (i.e., the violence of injustice and inequity; Makleff et al., 2023). This framework is underused in relation to, but is relevant for, abortion-related research, as it addresses the intersections between systems-level (macro) and individual-level (micro) aspects affecting abortion access (Nandagiri et al., 2020). A structural violence framework considers how "legal and political structures that restrict access to abortion often intersect with sociocultural structures, leading to socioeconomic disadvantages and stigma, which further fuel barriers to abortion" (Makleff et al., 2023, p. 3). Individuals living in states where abortion is illegal or highly restricted face disadvantages, which are compounded for those who are financially insecure and cannot afford to travel (Makleff et al., 2023; Nandagiri et al., 2020), as well as those who face structural inequities and discrimination at a broad level, such as LGBTQ + people and people of color—individuals who may be additionally scrutinized for their decisions related to contraception, family planning, and parenthood (Dawson & Leong, 2020).

Rationale for the Current Study

Access to abortion is arguably a component of essential healthcare that guarantees the full range of human rights, including bodily autonomy (U.S. Department of Health and Human Services, 2022). Access to abortion encompasses access to lifesaving care that may be needed in the event of pregnancy complications (e.g., ectopic pregnancy) or miscarriage—which is especially important for bisexual women given their risks in these areas (Januwalla et al., 2019). Furthermore, limited access to abortion often means less access to other reproductive healthcare services, including contraception, mental health counseling, cancer screenings, prenatal care, interpersonal violence screening, and STI screening (U.S. Department of Health and Human Services, 2022). Existing work suggests that reproductive healthcare quality declined in at least some communities post-*Roe* (Grossman et al., 2023), and there is a growing consensus among OB/GYNs that overturning *Roe* has resulted in worsened maternal healthcare outcomes, particularly in at-risk groups (e.g., Black women; Fredericksen et al., 2023). Half of OB/GYNs in states where abortions are banned have reported patients in their care who have wanted an abortion but were unable to obtain one due to their state's policies (Fredericksen et al., 2023). Furthermore, in the first six months of 2023, births rose by an average of 2.3% in states that enforced total abortion bans compared to abortion-protected states, with larger effects observed in younger women, in women of color, and in states bordered by other ban states (Dench et al., 2023).

Research is needed, then, that explores the perceived consequences of the *Dobbs* decision for vulnerable groups, and, in particular, members of the LGBTQ + community (e.g., bisexual women partnered with men) who may be at elevated risk of unintended pregnancy—for example, because of barriers to contraception, greater risk of sexual violence, and lack of LGBTQ + -inclusive healthcare (Januwalla et al., 2019; Jones et al., 2018; Tabaac et al., 2022).

Our focus on LGBTQ people who were also new parents was grounded in our supposition that they might feel particularly vulnerable with respect to not only the *Dobbs* decision but also the "slate of hate" against LGBTQ + people, which is advancing across the U.S., but is concentrated in many of the same states with more restrictive abortion laws (Choi, 2023; Klein & Gruberg, 2023). Anti-LGBTQ + and anti-abortion laws are often introduced and passed simultaneously, reflecting coordinated efforts in state governments (Cyr & Holder, 2022). In 2023 alone, more than 500 anti-LGBTQ + bills were introduced or passed that prohibit gender-inclusive restrooms, ban gender-affirming care, allow health providers to discriminate on the basis of religious beliefs, and prevent teachers from talking about LGBTQ identities (Choi, 2023).

Method

Procedure

Participants ($N = 99$)—all members of the LGBTQ + community who were AFAB—were recruited via Prolific, an online recruitment platform that uses specialized

targeting techniques to share surveys to pre-registered participants. Individuals were invited to participate in the study March–June 2023, almost one year after the *Dobbs* decision, based on the following selection criteria: (a) they were the parent of at least one biological child born between 2018 and 2023, and (b) they identified as LGBTQ+. Thus, although the larger project sought to include all LGBTQ parents who were new parents, in the current study, we limited our sample to AFAB people who had given birth, thus excluding 23 cis GB men and one trans woman.

All participants were rigorously prescreened by Prolific to ensure that they were eligible to participate. The survey, which included closed- and open-ended questions, was hosted on the online platform Qualtrics and took an average of 36.7 min to complete. It was approved by Clark University's institutional review board.

Sample Description

Our sample consisted of 81 cis women (81.8%), 17 nonbinary AFAB individuals (17.2%), and one trans man (1%). Among cis participants, 59 (72.8%) identified as bisexual, queer, or pansexual (BQ+) women partnered with cis men; ten (12.3%) as lesbian, bisexual, queer, or pansexual women (LBQ+) who were unpartnered; six (7.4%) as LBQ+ women partnered with cis women; four (4.9%) as LBQ+ women wish nonbinary partners; and two (2.6%) as LBQ+ women partnered with trans women. Among nonbinary participants, ten (58.8%) were partnered with cis men, three (17.6%) had nonbinary partners, three (17.6%) had trans women partners, and one (6.0%) was unpartnered. The trans man was partnered with a cis man.

Most participants ($n=77$; 77.8%) identified as White only; the remainder ($n=22$; 22.2%) were people of color, including biracial and multiracial individuals: namely, Black ($n=5$); Hispanic/Latinx ($n=6$); American Indian or Alaska Native (AI/AN; $n=1$); AI/AN and White ($n=3$); AI/AN and Latinx ($n=2$); Black/Asian ($n=1$); Black/White ($n=1$); AI/AN, Black, and White ($n=1$); Latinx/White ($n=1$); and "multiracial" ($n=1$). More than half ($n=53$; 53.5%) reported a household income (HI) of ≤ $50 K. Namely, 7 (7.1%) had an HI of < $12.5 K, 19 (19.2%) reported $12.5 K–$25 K, 27 (27.3%) reported $25,001–$50 K, 22 (22.2%) reported $50,001–$75 K, 12 (12.1%) reported $75,001–$100 K, and 12 (12.1%) reported > $100 K. The federal poverty level is $25 K for a family of 3; thus, over a quarter of the sample ($n=26$; 26.3%) met this threshold (HealthCare.Gov, 2023). Most participants considered themselves lower class ($n=18$; 18.2%), working class ($n=42$; 42.4%), or lower middle class ($n=20$; 20.2%), with the remainder endorsing middle class ($n=14$; 14.1%) or upper middle class ($n=5$; 5.1%). Forty-one (41.4%) were employed full-time, and 13 (13.1%) were employed part-time. Over one-third ($n=38$; 38.4%) identified as homemakers/stay-at-home parents, consistent with the fact that most had children < 4 years (not school-aged). Seven (7.1%) were unemployed. Most (86.5%) were ≤ 35 years. Namely, 23 (23.7%) were 19–25, 36 (37.1%) were 26–30, 25 (25.8%) were 31–35, 12 (12.4%) were 36–40, and one (1.0%) was 41–45 years. Two were missing age data.

More than two-thirds of participants had one child ($n=66$; 66.7%); almost one-quarter ($n=24$; 24.2%) had two children, four (4.0%) had three children, and five (5.1%) had four children. Eighty-eight (88.9%) had at least one child < 4 years. Namely, 21 (21.2%) had one child < 1 year, 22 (22.2%) had one child 12–23 months, 19 (19.2%) had at least one child 24–35 months (18 had one child, one had two), 26 (26.3%) had at least one child 36–47 months (25 had one child, one had two), and 46 (46.5%) had at least one child ≥ 4 years (39 had one child, five had two, one had three, and one had four). Six (6.1%) were pregnant. Most ($n=88$; 88.9%) had at least one child via intercourse with their partner, and four (4.0%) had at least one child via intercourse with someone other than their partner. Three (3.0%) had used intrauterine insemination to become pregnant, two (2.0%) had used in vitro fertilization to become pregnant, five (5.1%) had to stop taking hormones to get pregnant, and three (3.0%) had to start taking hormones to get pregnant. Six (6.1%) identified other ways they had become parents (e.g., sexual assault).

Fifteen participants (15.2%) reported having had an abortion. Thirty-four (34.3%) reported at least one pregnancy loss, 44 (44.4%) reported pregnancy complications, 12 (12.1%) reported experiencing gender dysphoria while pregnant, 49 (49.5%) reported one or more traumatic birth experience, and 68 (68.7%) reported having postpartum mental health issues.

Geographically, participants were from 34 states, with greatest concentrations in TX (11), OH (8), NC (7), PA (6), FL (6), MI (6), and IL (5). Over one-quarter ($n=25$; 25.3%) lived in a state where abortion was banned (11 in TX, 3 in TN, 2 in KY, 2 in IN, 2 in MS, 2 in OK, 1 in AL, 1 in AR, 1 in LA). Seventeen (17.2%) lived in a state with gestational limits (6–18 weeks) (7 in NC, 6 in FL, 2 in GA, 1 in SC, 1 in UT). Eleven (11.1%) lived in a state where a ban had been initiated but blocked (8 in OH, 2 in WI, 1 in IA). Thus, 53 participants (53.5%) lived in a state with at least some restrictions. Forty-six (46.5%) lived in a state where abortion was legal, and in some cases, they had introduced additional protections (Guttmacher, 2023; New York Times, 2023).

Measures

Closed-Ended Questions

In addition to demographic items (i.e., assessing gender, sexual orientation, age, race, income, partnership status, employment status, geographic location, and details about children and parenthood route), a variety of closed-ended questions assessed concerns about access to reproductive and sexual health (see Table 1). Additionally, we asked participants about their reactions to the overturning of *Roe* (upset but not surprised, upset and surprised, neutral, pleased and surprised, pleased but not surprised). Finally, we asked participants about whether they had considered moving to another state and/or whether they had taken steps to do so.

Open-Ended Questions

Participants were asked several open-ended questions to capture their experiences of and perceived impact of the overturning of *Roe*. These included the following: (1) In June 2022, *Roe v. Wade* was overturned. The U.S. Supreme Court issued their decision in *Dobbs v. Jackson Women's Health Organization*, which determined that the U.S. Constitution does not confer a right to abortion. How do you feel about this decision? (2) How, if at all, has the overturning of *Roe v. Wade* shaped your future family-building plans? (3) If relevant and applicable to you and/or the type of sex you have: (How) has the overturning of *Roe* impacted your sexual or reproductive life? (4) Has the introduction and/or passing of specific bills or laws in your state impacted your desire to remain in your state? Please elaborate.

In addition to examining participants' responses to the above questions, we also reviewed participants' responses to other less directly relevant questions, such as those related to parenting and state climate. For example, we asked participants to "please share any other relevant experiences as an LGBTQ + parent living and parenting in 2023."

Data Analysis

A mixed-methods approach, using quantitative and qualitative data, allowed for a more complete, nuanced analysis (Creswell & Plano-Clark, 2018). Specifically, it afforded us a deeper understanding of the perceived consequences of the *Dobbs* decision for LGBTQ + people.

Quantitative Analysis

Basic descriptive statistics were calculated for the full sample and, in some cases, by abortion policy context. We examined whether concerns related to pregnancy, abortion, and contraception differed by policy context using a series of chi-square tests. Policy context was categorized in two ways: (1) *abortion-legal state* vs. *abortion ban state* and (2) *abortion-protected state* vs. *abortion-hostile state*, where abortion-hostile states represent states where abortion has been banned, highly restricted (i.e., there are gestational limits), or contested (i.e., bans were introduced but blocked, and the legality of abortion is under dispute; New York Times, 2023). In turn, we were able to determine whether worries were, for example, elevated only for those living in abortion-ban states or whether such worries might extend to a broader group of people living in abortion-restrictive (hostile) states: Prior work (e.g., Goldberg & Abreu, 2023; Kazyak, 2015) indicates that legal uncertainty itself can create anxiety for LGBTQ + people in structurally stigmatizing contexts. In reporting the qualitative data, we generally characterize participants according to whether they lived in an abortion-hostile vs. abortion-protected state.

Qualitative Analysis

Responses to the open-ended survey portions ranged from one sentence to several paragraphs of text, with most participants providing responses of three to five sentences. The first and second authors used thematic analysis (Braun & Clarke, 2006, 2013) to examine responses from the open-ended portions of the survey.

The authors' analysis focused on participants' reflections on the impact of *Dobbs* on their reproductive autonomy and well-being. The analysis was informed by our research question, prior literature, and a structural stigma framework. The first author initially read all open-ended responses to gain familiarity with the data, including overarching themes in responses. She made note of, and bracketed, her own experiences and preconceptions to facilitate a curious and open stance in relation to the data, and the ability to approach the data with a fresh perspective (Goldberg & Allen, 2015). Then, responses were annotated: that is, via line-by-line coding, she labeled phrases relevant to the primary domains of interest (e.g., fear and anger). These codes were abstracted under larger categories and subcategories, which were positioned in relation to each other, such that connective links were established (e.g., emotional responses to the *Dobbs* decision and perceived vulnerability to consequences of the decision) in an effort to meaningfully describe participants' experiences as queer and AFAB new parents a year after *Roe* was overturned. A tentative scheme was produced and reapplied, such that all data were then recoded according to the revised scheme. Themes were analyzed for the full sample and by key demographics, such as the legal context surrounding abortion in their state (abortion-hostile vs. abortion-protected) as well as by sexual orientation and race/ethnicity. The third author served as an auditor and provided

critical input at various stages of the coding process, as detailed below.

Trustworthiness. To enhance trustworthiness in the study preparation and data collection phases, we pursued a data collection strategy (i.e., an online survey) that we believed would result in high-quality, contextually valid data (Lincoln & Guba, 1985). We also posed both open- and closed-ended questions to obtain multiple forms of data that would lend themselves to a deeper, richer understanding of the phenomena of interest (Morrow, 2005).

To enhance trustworthiness in the data analysis process, our research team sought to maintain reflexivity through open discussion of our assumptions and positionality throughout the process of examining, organizing, and interpreting the data (Morrow, 2005). To further enhance the credibility of the analysis, the second author reviewed several versions of the coding scheme, providing input on each iteration and collaboratively examining the fit between the data and the emerging themes (Goldberg & Allen, 2015). Upon review of the final coding scheme, the third author made several suggestions for reorganization and changes were integrated accordingly into the final thematic structure. After reaching the final thematic structure, the coders noted the absence of any new concepts, codes, or themes, indicating that data saturation had been reached (Lincoln & Guba, 1985). Finally, the authors selected meaningful and appropriate quotes from participants to include in the paper to illustrate key concepts (Morrow, 2005). Of note is that in presenting quotes, we use pseudonyms for all participants.

Findings

Reactions to Overturning of Roe

Most participants endorsed being either "upset but not surprised" ($n = 56$; 66.7%) or "upset and surprised" ($n = 24$; 28.6%) about the overturning of *Roe*. Three (3.6%) endorsed a "neutral" reaction, and one (1.2%) was "pleased but not surprised". Notably, the latter four participants lived in states where abortion was contested. Fifteen did not answer this question.

Fear, terror, and outrage were among the top emotions detailed by participants who lived in states where abortion was banned, restricted, or contested. Marisa, a White cis pansexual woman in Indiana said, "I feel terrified, as a woman with a uterus, a menstrual cycle, that *Roe* was overturned by those who live a life of privilege." Haley, a White cis bisexual woman in Ohio said, "It's gut wrenching to me as a female, especially having had a complicated pregnancy. It feels like my own mother had more reproductive rights than I do now."

Such participants often voiced rage that such a decision about AFAB people's bodily autonomy could be made by cis men. Chandra, a Black cis bisexual woman in South Carolina, said, "It should not be the decision of old White men whatever women in this country decide to do with their bodies. Taking away abortion is dangerous." In addition to identifying the broader societal implications of the decision ("People will die because of this, and millions of children will be born into homes where they weren't necessarily wanted"), participants highlighted the relevance of the decision for themselves ("I'm worried if I'm pregnant and there is a condition during the pregnancy that would kill both myself and the baby, my right to an abortion would be taken away and I might die"). Rory, a White nonbinary bisexual parent in Texas, said:

> Once I found out I was pregnant with baby #2, currently 22 weeks, I was panicking, and I do worry about giving birth or being unable to carry to term due to a variety of reasons and how it could affect me being in a state where AFABs have no bodily autonomy.

Participants who lived in abortion-protected states frequently described anger and outrage, but less often voiced fear and terror. Some mentioned their state's laws in explaining that while they were upset about *Dobbs*, they were not personally worried. Nikki, a Black cis bisexual woman, shared, "It doesn't affect me as much because California is a blue state and hopefully it stays like that." Laurie, a White cis bisexual woman, reflected, "I'm grateful to live in Minnesota where the state is very liberal...but I worry about other decisions that could be overturned, [like] marriage equality." Laurie was one of several participants who voiced concern about other rights that might be threatened, even in abortion-protected states (e.g., "I've seen some states banning gender-affirming care; I'm scared that will be taken away").

The few participants who voiced neutral responses—all of whom lived in abortion-hostile states—tended to distance themselves from the issue, stating that there was "little that they could do about it." They asserted that they had no control over what the government did, and therefore tried to "simply exist." The overturning of *Roe* did not seem to weigh heavily on their minds; in addition, they voiced little agency over the matter. Jen, a White cis bisexual woman in Kentucky, said, "I think I don't need to worry about those things because there's nothing I can do about it." Molly, a White cis asexual woman in Alabama, said, "Not much

changed for me. Since I need to live my life, I make no actions to change anything. I duck my head and deal with the status quo."

Considering One's Own Axes of Marginalization vs. Privilege

Some participants spoke to how the overturning of *Roe* would have disproportionate impacts, often highlighting their own vulnerabilities as members of marginalized groups—for example, as Black, queer, and/or low income. Eve, who lived in Florida, named her intersectional identities in highlighting her reactions to and concerns about the decision, stating, "Being a Black queer woman, the effects of the ruling are outsized for me. My demographic already has the worst maternal outcomes. This is essentially a death sentence for many people like me." Lee, an American Indian/White cis bisexual woman in Kansas, shared:

> This decision enrages me. My first pregnancy was very difficult and I nearly died during childbirth, and we almost lost our daughter. I think it hits me more as a part-Indigenous woman, a subset with the highest level of violence experienced. Many Indigenous women will find themselves stuck in dangerous relationships because of this decision.

Low-income participants noted their lack of resources as a factor that rendered them additionally vulnerable. Carrie, a White cis bisexual woman in Massachusetts, said, "As a lower income American, it terrifies me. I am not financially able to have another child, and I cannot imagine being forced to have a child I didn't want." Some noted that not only could they not afford to raise another child ("I don't know if I would have enough food stamps, WIC, or money"), they also could also not afford an abortion, given barriers to access. Denise, a White cis bisexual woman in Oklahoma, said, "I live in absolute fear of becoming pregnant again, knowing that I don't have the...resources to travel through multiple states for care."

Likewise, a few participants emphasized their privilege, including race, relationship type, income, and where they lived, as a factor that buffered them from the full range of effects associated with the overturning of *Roe*. Megan, a White cis bisexual woman who was "furious" about *Dobbs*, and who lived in Pennsylvania, where abortion was legal, said:

> I feel very, very lucky that I am a relatively well-off person who could afford to travel for reproductive care; that my wealth level, education, and race encourages doctors to listen to me; that I am cisgender and straight-passing enough so that I don't get hassled; and that I've never experienced sexual violence.

Ava, a White cis bisexual woman in Connecticut, shared:

> As a White cis female on the Northeast Coast with a White cis man I have felt very privileged to not deal with the full effects as other women have experienced. I have great empathy to the women, trans men, and AFAB nonbinaries who have had their lives disrupted because of the government controlling their bodies' healthcare.

Concerns About Reproductive and Sexual Healthcare

We asked participants about their level of worry (very, somewhat, neutral/mixed, not very, not at all) about reproductive and sexual healthcare, post-*Roe*. For descriptive purposes, we report these in Table 1. While our primary focus was on the qualitative narratives, responses to these items provide grounding for their narrative accounts, discussed below.

Of particular interest to us was the proportion of participants who endorsed being "very worried" about issues related to reproductive and sexual healthcare, insomuch as this indexed a level of concern that was more intense, immediate, and personal than those who were "somewhat worried," and certainly more than those who expressed feeling "neutral," "not very worried," and "not at all worried." We found that 46% of the sample was very worried about having an unintended pregnancy, with more than twice as many participants in abortion-hostile states endorsing this than those in abortion-protected states (60.4% vs. 28.9%), a difference that was significant ($X^2(1, 98) = 9.71$, $p = 0.002$), although when considering participants in abortion-ban states vs. abortion-legal states, this difference was only marginally significant ($X^2(1, 98) = 2.68$, $p = 0.080$). Almost 29% of the sample endorsed being very worried about access to birth control, with those in abortion-hostile states marginally more likely to endorse this than those in abortion-protected states (35.8% vs. 20%; $X^2(1, 98) = 3.09$, $p = 0.064$); when considering participants in abortion-ban states vs. others, this difference was significant ($X^2(1, 98) = 8.33$, $p = 0.005$). Similarly, almost 32% of the sample was very worried about access to emergency contraception; those in abortion-hostile states were marginally more likely to endorse this as those in abortion-protected states (39.6% vs. 22.7%; $X^2(1, 98) = 2.55$, $p = 0.083$); when considering participants in abortion-ban states vs. others, this difference was significant ($X^2(1, 98) = 5.71$, $p = 0.017$).

Table 1 Concerns about sexual and reproductive healthcare access

Concerns …How concerned or worried do you feel about…	Abortion-hostile ($n=53$), n (%)	Abortion-protected ($n=45$), n (%)	Total ($n=98$), n (%)
Accessing birth control (IUD, pill, patch, ring, etc.)?			
Very worried	19 (35.8)	9 (20.0)	28 (28.6)
Somewhat worried	12 (22.6)	12 (26.7)	24 (24.5)
Neutral	5 (9.4)	4 (8.9)	9 (9.2)
Not very worried	6 (11.3)	13 (28.9)	19 (19.4)
Not at all worried	7 (13.2)	3 (6.7)	10 (10.2)
Not worried because not having a type of sex that carries pregnancy risk	4 (7.5)	4 (8.9)	8 (8.2)
Accessing emergency contraception (i.e., morning after pill)?			
Very worried	21 (39.6)	10 (22.2)	31 (31.6)
Somewhat worried	17 (32.1)	13 (28.9)	30 (30.6)
Neutral	2 (3.8)	5 (11.1)	7 (7.1)
Not very worried	4 (7.5)	11 (24.4)	15 (15.3)
Not at all worried	5 (9.4)	1 (2.2)	6 (6.1)
Not worried because not having a type of sex that carries pregnancy risk	4 (7.5)	4 (8.9)	8 (8.2)
Experiencing unintended pregnancy?			
Very worried	32 (60.4)	13 (28.9)	45 (45.9)
Somewhat worried	9 (17.0)	14 (31.1)	23 (23.5)
Neutral	2 (3.8)	7 (15.6)	9 (9.2)
Not very worried	0 (0)	5 (11.1)	5 (5.1)
Not at all worried	5 (9.4)	2 (4.4)	7 (7.1)
Not worried because not having a type of sex that carries pregnancy risk	5 (9.4)	4 (8.9)	9 (9.2)
Accessing abortion pills (medication abortion)?			
Very worried	26 (49.1)	20 (44.4)	46 (46.9)
Somewhat worried	14 (26.4)	10 (22.2)	24 (24.5)
Neutral	3 (5.7)	3 (6.7)	6 (6.1)
Not very worried	1 (1.9)	6 (13.3)	7 (7.1)
Not at all worried	5 (9.4)	2 (4.4)	7 (7.1)
Not worried because not having a type of sex that caries pregnancy risk	4 (7.5)	4 (8.9)	8 (8.2)
Accessing in-clinic abortions (surgical abortion)?			
Very worried	29 (54.7)	23 (51.1)	52 (53.1)
Somewhat worried	12 (22.6)	8 (17.8)	20 (20.4)
Neutral	1 (1.9)	3 (6.7)	4 (4.1)
Not very worried	1 (1.9)	5 (11.1)	6 (6.1)
Not at all worried	6 (11.3)	2 (4.4)	8 (8.2)
Not worried because not having a type of sex that caries pregnancy risk	4 (7.5)	4 (8.9)	8 (8.2)
Accessing in vitro fertilization (IVF)?			
Very worried	8 (15.1)	4 (8.9)	12 (12.2)
Somewhat worried	3 (5.7)	4 (8.9)	7 (7.1)
Neutral	10 (18.9)	9 (20.0)	19 (19.4)
Not very worried	11 (20.8)	12 (26.7)	23 (23.5)
Not at all worried	16 (30.2)	12 (26.7)	28 (28.6)
Not worried because not having a type of sex that caries pregnancy risk	5 (9.4)	4 (8.9)	9 (9.2)
Having a limited number of providers who can provide reproductive and sexual healthcare to me?			
Very worried	27 (50.9)	15 (33.3)	42 (42.9)
Somewhat worried	13 (24.5)	13 (28.9)	26 (26.5)
Neutral	1 (1.9)	3 (6.7)	4 (4.1)
Not very worried	1 (1.9)	10 (22.2)	11 (11.2)
Not at all worried	7 (13.2)	0 (0)	7 (7.1)
Not worried because not having a type of sex that caries pregnancy risk	4 (7.5)	4 (8.9)	8 (8.2)

Table 1 (continued)

Concerns …How concerned or worried do you feel about…	Abortion-hostile ($n=53$), n (%)	Abortion-protected ($n=45$), n (%)	Total ($n=98$), n (%)
Having to drive or travel long distances to receive appropriate reproductive and sexual healthcare?			
Very worried	30 (56.6)	15 (31.1)	45 (45.9)
Somewhat worried	12 (22.6)	7 (15.6)	19 (19.4)
Neutral	1 (1.9)	7 (15.6)	8 (8.2)
Not very worried	1 (1.9)	11 (24.4)	12 (12.2)
Not at all worried	5 (9.4)	2 (4.4)	7 (7.1)
Not worried because not having a type of sex that caries pregnancy risk	4 (7.5)	4 (8.9)	8 (8.2)

One participant was missing data on these items

Echoing this pattern, nearly half of the sample was very worried about having a limited number of providers who could offer reproductive and sexual healthcare to them (42.9%), with greater numbers of participants in abortion-hostile states worrying about this than those in abortion-protected states (50.9% vs. 33.3%), a difference that was marginally significant ($X^2(1, 98)=3.08$, $p=0.060$), as well as when considering participants in abortion-ban states vs. others ($X^2(1, 98)=2.37$, $p=0.096$). Almost half of the sample (45.9%) was very worried about having to travel long distances to receive appropriate reproductive/sexual healthcare, with significantly more participants in abortion-hostile states endorsing this than those in abortion-protected states (56.6% vs. 31.1%; $X^2(1, 98)=6.39$, $p=0.010$), a difference that dropped to a trend when considering individuals in abortion-ban states vs. others ($X^2(1, 98)=3.09$, $p=0.064$). Although few participants endorsed being very worried about accessing in vitro fertilization (12.2% of the sample), the number was twice as high for those in abortion-hostile states as those in abortion-protected states (15.1% vs. 8.9%); with cell sizes <5, no chi-square tests were performed.

Over half (53%) of participants were very worried about accessing in-clinic surgical abortions. Similar numbers of individuals in abortion-hostile and abortion-protected states were concerned about access to in-clinic abortions (54.7% vs. 51.1%; $X^2(1, 98)=0.06$, $p=0.48$); likewise, the difference was not significant for those in abortion-ban states vs. others ($X^2(1, 98)=0.03$, $p=0.52$). Almost half (47%) of participants were very worried about accessing medication abortion, with similar numbers in abortion-hostile states and abortion-protected states indicating that they were very concerned (49.1% vs. 44.4%; $X^2(1, 98)=0.11$, $p=0.45$); similarly, the difference was not significant for those in abortion-ban states vs. others ($X^2(1, 98)=0.28$, $p=0.38$).

Impacts of Dobbs on Participants' Future Plans and Overall Well-Being

Participants' responses shed insight into several different ways that the overturning of *Roe* had affected their future plans (e.g., regarding future childbearing and where to live) as well as their current well-being (e.g., including sexual and emotional functioning). Specifically, their narratives reveal the impact of *Dobbs* on their family planning, fear of unintended pregnancy, sexual well-being, mental health, and relocation considerations. Those who lived in abortion-hostile states often reported greater or more intense concerns in these domains.

Family Expansion Plans

Some participants described how the overturning of *Roe* had impacted their concerns about and decision-making regarding future children. These patterns were generally similar regardless of whether they lived in abortion-protected versus abortion-hostile states. About one-third of participants explicitly shared that they were not planning to have any more children, with several participants asserting they were putting future pregnancy plans on hold (e.g., until they moved). Allie, a White cis pansexual woman in Rhode Island, said, "The overturning of *Roe v. Wade* has made me decide I will not at all be having any more children, despite a prior desire to do so." Erin, a White bisexual cis woman in Texas, recounted her dismay upon realizing that with the overturning of *Roe*, "even if something went wrong in the pregnancy, I would have no choice but to continue...It played a part in deciding not to have any more [children]." Danielle, a White cis bisexual woman in Ohio, shared how her fear of being unable to terminate a wanted but medically complicated pregnancy had solidified her decision not to have more children:

> We did not. . .try for children while Donald Trump was in office due to feeling of unease. Due to *Roe v. Wade* being overturned we have also decided to stop having children after having my son in 2021. I had a lot of pregnancy complications and my state would ban abortion care at 6 weeks. It simply does not feel safe to even pursue a pregnancy. It definitely made us more confident in only having one child.

Some of these participants shared that the *Dobbs* decision had made them want fewer children in that they did not want to bring more children into a world where AFAB individuals were so vulnerable and devalued ("Anti-choice policies made me terrified to have daughters"). Others indicated that the Dobbs decision, alongside broader sociopolitical considerations, such as racism, the rise in anti-LGBTQ + sentiment, and climate change, contributed to their aversion to having more children. Sasha, a White nonbinary pansexual parent in New Jersey, said:

> I would never choose to bring another child into this world and regret bringing my poor daughter into this crap as it is. I fear for a future of climate [change] and gun violence; I can't even think about sending them to school without being afraid they will be gunned down, let alone the discrimination we face as queer parents. I already have a lifetime of prejudice outlined for my child, thanks to the hatred and bigotry promoted in this country.

About one-third of participants asserted that the overturning of *Roe* had not changed their family-building plans (i.e., the number of children they wanted). Typical responses were "It hasn't had any impact on my plans" and "No, I don't think I am done." Rarely, participants elaborated to note that while they found it difficult to parent within the current sociopolitical climate ("it makes it scarier to be a parent"), they still hoped to have additional children. Several of those who lived in abortion-protected states emphasized that their intentions to do so were predicated on their ability to remain in their current city and state.

The remainder of participants articulated plans that were less definitive and/or less tied to *Roe* specifically. Some said that they did not think they would have more children but had made the decision prior to the overturning of *Roe*, with noting that they always planned to have just one child. Others voiced uncertainty about having additional children as a result of *Dobbs*, such that they were "leaning" towards not having any more, but were as of yet undecided.

Fear of Unintended Pregnancy and Pregnancy Complications

Echoing the quantitative data (Table 1), wherein 45 participants (45.9%; 32 in abortion-hostile states, 13 in abortion-protected states) were "very worried" about an unintended pregnancy, many participants voiced amplified concerns about an unintended pregnancy since *Dobbs*. Those in abortion-hostile states were especially emphatic in asserting that they were "terrified" about needing to seek an abortion given the "backwards" laws in their state—to address not only an unintended pregnancy but also in the event that they encountered medical complications associated with a wanted pregnancy. In some cases, prior experiences with traumatic pregnancies and births contributed to intensified and multilayered fears regarding how the overturning of *Roe* might impact them: for example, they worried about a miscarriage that could "result in me being wrongfully accused of hurting my baby." Eli, a White nonbinary asexual parent in Michigan, said, "As someone who had to have an abortion due to a rape by my close family member...How is it in the realm of possibility that I [would] have to face the situation of birthing my brother's baby or killing myself?".

Lack of a financial safety net were often intertwined with fears of unintended pregnancy. Participants bemoaned the lack of community support for low-income people having babies, whereby most people like them were "in survival mode, barely scraping by, can't afford babysitters." They feared a situation where they could not afford another child or an abortion.

Notably, for some participants, fear of an unplanned pregnancy had led to changes in their approach to contraception—and, consistent with the quantitative data, those who described such changes were typically those in abortion-hostile states. Some noted that they were more "careful" when they had sex—for example, having their partners "pull out," using multiple forms of protection, and tracking their cycle. Others had made major changes in their contraceptive methods, such that they were now using long-acting reversible contraception (LARC), such as intrauterine uterine devices (IUDs), or pursuing permanent methods (e.g., tubal ligation). Lila, a cis White bisexual woman in Texas, said, "It is terrifying. What if I need an abortion for medical reasons? I don't want any more children, so when they made abortion illegal in Texas, I got an IUD." Vera, a White cis bisexual woman in Texas, said, "I will likely be getting my tubes tied soon. I want more children, but with two previous C-sections and a state that doesn't care about

my health or well-being, it feels like too big of a risk to try again." Callie, an American Indian cis bisexual woman in North Carolina, planned on "getting sterilized within the next two years."

Others, mostly in abortion-protected states, shared that the overturning of *Roe* had not affected their contraception methods. Several of them volunteered that they were already using (sometimes multiple forms of) contraception, whereas several others elaborated that they were not having the type of sex that would produce a pregnancy.

Sexual Well-Being: Pleasure, Desire, and Ease

For some participants, the overturning of *Roe* had not just created a pervasive sense of anxiety surrounding the potential for unintended pregnancy—but, this anxiety severely interfered with their sexual functioning. About one-sixth of participants, all but one in abortion-hostile states, voiced that their anxiety about pregnancy had reduced their desire or enjoyment of sex. The overturning of *Roe* had "made sex scarier" and "dropped my desire 100%," resulting in anxiety "before and after sex," leading to less pleasure. Taryn, a White cis bisexual woman in Ohio, said, "It has made me a lot more anxious about sex because I don't want to have any more children, and I am worried about my health if I were to get pregnant again." Denise, a White cis bisexual woman in Oklahoma, spoke to the pervasive impact of increased anxiety surrounding sex and possible pregnancy, which included but was not limited to her sexual relationship:

> The overturning made me more anxious around sex. I have a constant fear that my form of birth control will fail and I will find myself pregnant. I am constantly taking pregnancy tests and going to the doctor the second a period is late. It is exhausting and makes me much less affectionate towards my partner.

Some participants, in abortion-hostile and abortion-protected states, shared that they were having less sex as a result of *Dobbs*. Simone, a White cis bisexual woman in Ohio, said, "My husband and I have definitely had less sex, as we're both worried about an accidental pregnancy. I don't know that he fully understands the magnitude of my fears, but he is supportive."

Finally, some participants, mostly in abortion-protected states, shared that *Dobbs* had not impacted their sexual desire, enjoyment, or frequency. Some noted that they were already not having much sex (e.g., because of illness, medications, or recovering from pregnancy or birth). Others simply noted that they were not having the type of sex that would produce a pregnancy.

Mental Health and Sense of Safety

Some participants, all in abortion-hostile states, volunteered that the overturning of *Roe* had impacted their overall sense of well-being and safety. Specifically, the *Dobbs* decision had amplified existing worries and raised new ones, impacting their physical and mental health, including their level of stress, depression, and anxiety ("*Roe v. Wade* was a big factor in my mental health as a parent this year; after suffering an extremely traumatic pregnancy...the possibility of getting pregnant and actually losing my life this time haunts me"). Maggie, a White cis bisexual woman in Missouri, said, "[The decision] broke me. My mental health plummeted. Having birthed one child from assault, I wanted to die the day it was overturned." Eli, a White nonbinary asexual parent in Michigan, who shared that in the past they had had an abortion after being raped, said, "I grieved for weeks. Mainly for myself, but also my daughter."

Some participants, all in abortion-hostile states, shared that the overturning of *Roe*, in combination with their states and/or communities' overall climate, had impacted their sense of emotional and physical safety. Commenting on her community's reaction to the ruling, Olivia, a White cis bisexual woman in Tennessee, said, "There was a celebration with prayer when *Roe* [was] overturned." These participants underscored how their sense of vulnerability was amplified by their sexual, gender, and/or racial identities. As people who were queer, trans, and/or of color, they experienced heightened concerns for their own and their family's sense of safety ("Dating another woman in my area, with all these redneck hard right people and a minority child—might as well tattoo 'hate crime me' on my face"). Ann, a White cis bisexual woman in Texas, shared her sense of fear and alienation in her community:

> Once I found out I was pregnant, I had a hard time accepting the current times we live in and how much of a battle it has been for the LGBTQ community. I'm afraid of never being accepted for who I am and the future of my children. . .I'd love my kids to love whoever they'd like and not feel ashamed of who they are. The overturning in abortion laws make me afraid of living in Texas, the major red state. If I cannot decide what happens to my body, then who does, the state? I fear for us in the LGBTQ community.

Relocation Considerations

Forty-five participants (45.5%) endorsed having "considered and/or taken steps toward moving" in response to the

introduction and/or passing of laws in their state. Namely, two-thirds ($n = 35$; 66.0%) of those in abortion-hostile states endorsed this, versus one-fifth ($n = 10$; 21.7%) of those in abortion-protected states, with a significant difference ($X^2(1, 98) = 19.49$, $p < 0.001$).

Participants who wished to move explained this by emphasizing only the overturning of *Roe* but also other legislation in their states, such as LGBTQ + and trans-specific legislation, as motivating factors. Commenting that their states "hated" them, as women, LGBTQ + people, and/or people of color, they felt "disgusted" living in such states, and longed to move elsewhere. "I considered other places to live due to laws against LGBTQ people, women, and cannabis," said Emory, a White cis queer woman in Texas. "I think about leaving the country at least once a week; it's so terrifying to stay here long-term," said Shayna, a White cis bisexual woman in Texas. Jaya, an American Indian cis pansexual/asexual woman in Oklahoma, shared:

> The restriction that does not allow for the gender change marker on my wife's driver's license [is stressful]. She avoids going to the doctor unless it's necessary because she will be misgendered. We can't afford to move, but hope to save up for a couple of years (if things don't get worse) and try to sell our home and move elsewhere.

Indeed, many participants in abortion-hostile states who wanted to move also identified barriers to doing so. These typically included finances ("We can't afford to move but I would like to") and being close to family ("All of our family and support is here"). Some spoke to their hope for the future, should these barriers become less insurmountable. Amanda, a White cis bisexual woman in Missouri, shared, "I am in such a red state. I haven't taken any steps [to move] because my income is so small and I get no support. But...I am going to school for education, and hopefully, in the end, [will earn] a higher income. So we'll see."

Most participants who indicated no interest in or plans to move were those in abortion-protected states. They generally indicated gratitude for where they lived (e.g., "Thank God our state is a safe haven for now"; "My state is one of the states taking steps to protect LGBT + residents"). Claire, a White cis bisexual woman in Illinois, shared:

> I recently had a miscarriage of our third child. I'm lucky enough to be in a state where abortion rights are protected for now, so I actually had access to the drugs that helped me expel tissue that my own body wasn't able to expel. Had I lived in another state—we moved from Arizona—I would not have been able to have access to those drugs and would likely have legal punishment for something I didn't even want to happen.

A few of those in abortion-protected states explained that they had recently moved from abortion (and LGBTQ +)-unfriendly states to more accepting and progressive states—and thus had no intention to move again. Jae, a White nonbinary bisexual participant in Washington, said:

> My child was born in Utah . . .the laws made it so I could lose my job if I talked about homosexuality in a positive light. The way that state legislature is heavily influenced by the LDS Church made me fear for the safety and well-being of my family. I was also concerned as a person who went through a difficult pregnancy that I might not be able to receive an abortion if I needed one in the future. The right choice for my family was to move to a state with better LGBT protections and better access to healthcare, so when the opportunity arose, we moved to Washington.

Those in abortion-hostile states who did not want to move generally elaborated to underscore their many reasons for staying ("I do not intend to move in the near future due to my son's father's ill health and the availability of a good education where we are"). Some noted that while the overturning of *Roe* was "bad," it was not enough to relocate.

Discussion

This mixed-methods study explored the perceived consequences of the *Dobbs* decision for members of the LGBTQ + community. Our findings reveal how a diverse group of LGBTQ + and AFAB individuals with young children—mostly consisting of bisexual cis women partnered with men, a group at greater risk of poor sexual and reproductive outcomes—expect *Dobbs* to impact their sexual, reproductive, and parenting lives. Our findings, too, offer broad insights into how the decision may be impacting LGBTQ + people across the U.S.

Several details about our sample are of note. First, our sample of cis and nonbinary AFAB queer individuals with young children reported high levels of birth trauma, pregnancy loss, and pregnancy complications, consistent with some other work documenting poorer outcomes in these and related areas among queer birthing individuals (Januwalla et al., 2019; Klittmark et al., 2023). Such experiences likely reflect these individuals' intersecting vulnerabilities (e.g., queer, low-income, and/or gender nonconforming) within dominant healthcare systems, which tend to be cis-normative and heteronormative (Gessner et al., 2020). Their experiences of pregnancy complications and loss and birth trauma also likely contributed to their fears of being unable to access reproductive healthcare, including abortion, should

they experience a high-risk pregnancy that necessitated interventions that might be illegal.

A second point of note is that many participants had incomes near or below the poverty threshold. LGBTQ+ individuals who live in poverty typically face more limitations in terms of access to reproductive healthcare—and, in particular, LGBTQ+-inclusive healthcare (Wilson et al., 2023). Our participants' narratives suggest that the lack of financial resources amplified their worries about abortion access, underscoring the reality that *Dobbs* may exacerbate existing healthcare inequities (Dickey et al., 2022; Fredericksen et al., 2023).

A third notable point about our sample is that most participants had one child, and most participants were young parents and also had young children. In turn, our participants were still of childbearing age and had the reproductive capacity for more children (Centers for Disease Control, 2023)—yet many spoke to curtailing the number of children that they would have because of a complex constellation of fears and concerns, including their ability to get an abortion or other life-saving care if they needed it. This underscores the far-ranging effects of *Dobbs*, and its potential to affect different segments of parents differently.

Turning to our main findings, most participants endorsed being upset but not surprised about the overturning of *Roe*. Participants living in more structurally stigmatizing contexts tended to voice more intense responses, such as terror and anger, highlighting their worries about their own lives and safety in addition to their concern for the rights of others. Those in less structurally stigmatizing contexts tended to articulate feelings of anger but less often fear, in that they did not tend to feel personally vulnerable as a result of the decision. Interestingly, the few participants who endorsed a "neutral" response lived in abortion-hostile states. Their narratives suggested that they were not indifferent but rather recognized their lack of agency to do anything about the decision except perhaps to distance themselves from more intense feelings. Indeed, the tone of participants' responses as a whole echoes analyses of Twitter responses after *Roe* was overturned, which documented similar sentiments of disappointment and fear—although positive and pro-life-oriented responses were also noted (Mane et al., 2022), a theme that was likely underrepresented in our sample given their unique positionalities. Some participants explicitly invoked their race, income, and sexual orientation in explicating their sense of vulnerability vis-a-vis the *Dobbs* decision—and its implications for their ability to safely access reproductive care. They recognized that as low-income, queer, and/or racially minoritized people in the U.S., they would have fewer choices and face greater barriers should they face a dangerous or unintended pregnancy (Dickey et al., 2022; Mosley et al., 2022).

Importantly, we documented higher levels of concern about reproductive/sexual healthcare among participants in states with more restrictive abortion policies with regard to unintended pregnancy, access to contraception, and access to providers. Interestingly, despite their greater concerns about unintended pregnancy, participants in states with more restrictive abortion laws were not more concerned about their ability to get an abortion than those in states with less restrictive laws. This is largely a reflection of the reality that those in less restrictive states were more worried about abortion access than they were about unintended pregnancy: indeed, relatively high levels of worry were exhibited among those in abortion-restrictive states in terms of both unintended pregnancy and abortion. While it would be reasonable to wonder whether the lower level of worry about unintended pregnancy among those in less restrictive states might reflect less concern about resources (i.e., they have more income), follow-up analyses indicated this not to be the case: income category did not differ significantly by state legislative context. Perhaps those in less restrictive states were responding to questions about abortion access less with their own state in mind and more with the general federal landscape in mind. Also, participants in both legislative contexts may not have been fully knowledgeable about the laws in their state and the ease of accessing an abortion amidst these laws, thus diluting differences between the two contexts; indeed, prior work suggests that even in abortion-ban states, not all residents understand the meaning and implications of the law (Jozkowski et al., 2023; Lerma et al., 2023).

Participants' open-ended responses helped to illuminate more fully the impact of the overturning of *Roe* on their lives and well-being, with legislative context again emerging as salient in nuancing their experiences. Some, particularly those in abortion-hostile states, said that *Dobbs* had solidified their decision not to have more children. In explaining this, these parents emphasized their fear of pregnancy complications that might necessitate access to medical care, as well as their concerns surrounding safety and sociopolitical climate, consistent with recent work documenting broader concerns about parenting at a time of racial unrest, political upheaval, and heightened homophobia (Abaied et al., 2022; Goldberg et al., 2022). In contrast, most of those participants who said that their intended family size had not changed lived in abortion-protected states—which is consistent with the reality that individuals in states with greater abortion access often have access to more family-building resources (Fischer et al., 2018).

Amidst prior pregnancy complications, miscarriages, and traumatic births, some participants voiced fears about the possibility of needing life-saving care in a state that criminalized abortion—fears that directly spoke to the worsened maternal healthcare outcomes, and possibly elevated mortality risk, in states with restrictive abortion policies (Fredericksen et al., 2023). Such fears led to changes in contraceptive method or approach for some, and negative impacts on

sexual well-being and desire for others. Sexual well-being, which is impeded by disruptions to sexual and reproductive autonomy, is a key component of overall well-being, and associated with mental and physical health outcomes (Byers & Rehman, 2014). Sexual satisfaction is also a component of relational health and is related to overall relationship quality (Yildiz, 2015). In turn, possible linkages between the legislative context and sexual ease, desire, and frequency are not insignificant; such connections underscore the legitimacy of sexual health as a public health concern (Mitchell et al., 2021).

Beyond sexual well-being, participants also spoke to how *Dobbs* had impacted their mental health, causing them to "grieve" the loss of their reproductive autonomy and fostering a sense of hypervigilance surrounding their own and their families' safety—a feeling that was especially heightened among individuals who described themselves as multiply and often visibly minoritized (i.e., queer, trans, and of color). The overturning of *Roe* was discussed in terms of the multiple intersecting oppressions (and associated safety concerns) that participants experienced within their communities. These findings echo other work documenting how Black lesbian mothers experienced heightened fears surrounding their families' safety amidst the intersectional risks posed by the Trump presidency (Radis & Nadan, 2021). The mental health concerns voiced by some of our participants raise concern, given that restrictions in abortion access are linked to greater stress and anxiety (Biggs et al., 2020).

Among our participants, one way of dealing with personal distress and distrust of state government was to consider and even initiate relocation—among those who had the ability to do so. Many participants in abortion-hostile states had considered moving, feeling that their states "hated" them because of their gender, sexual orientation, and/or race. This feeling may reflect the importance of social safety for LGBTQ + and other marginalized people—namely, the idea that individuals desire not only the absence of discrimination and victimization, but also want to feel included and affirmed in their social environments (Diamond & Alley, 2022). Yet similar to other work that has documented how LGBTQ + people's ability to escape politically charged and oppressive state climates is often limited by other factors, such as financial resources and caregiving responsibilities (Goldberg & Abreu, 2023; Goldberg et al., 2013), our participants often spoke to how lack of resources left them with little choice or hope of leaving their state. This reveals how reproductive justice issues impact individuals unevenly, with some individuals—such as those in abortion-hostile states who are also queer, poor, and/or of color—suffering disproportionately as compared to those who have more privileges, and who live in or can escape to affirming legal contexts (Charlton, 2022; Grossman et al., 2023).

Limitations

There was a great deal of diversity and intersectionality within our relatively small sample which presents complexity in terms of generalizability. Future work should aim to examine how individuals with identities not well represented in our sample, such as female-partnered women and trans men, experience the overturning of *Roe*. Also, we did not explicitly explore how participants' experiences of birth and pregnancy—including traumatic and complex experiences—shaped their concerns related to the overturning of *Roe*. And, in that our study was cross-sectional, it provides only a snapshot of individuals' perceptions and experiences at one point in time; longitudinal work is needed to address how feelings and experiences related to *Roe* (e.g., relocation) unfold over time. In that we focused on individuals instead of couples, we are limited in our understanding of how the overturning of *Roe* affects the couple/family unit (e.g., decision-making regarding family-building and relocating); future work can focus on couples' experiences. Furthermore, while our study helps to illuminate the short-term consequences of *Dobbs*, it will be important for future research to investigate the long-term psychological, emotional, social, and sexual implications of this national decision. Finally, our findings may not generalize to people who have not yet had children. The overturning of *Roe* may indeed be shaping who does and does not become a parent altogether.

Implications for Practitioners, Policymakers, and Researchers

Our findings hold implications for practitioners who work with LGBTQ + people and other marginalized groups who may be experiencing threats to their reproductive autonomy alongside growing hostility and even legislation directed at their intersectional identities. Located in both abortion-friendly and abortion-hostile states, participants offered a range of perspectives regarding their feelings about and perceived consequences of the *Dobbs* decision. Given the limited research thus far on individuals' perspectives in a post-*Roe* world, their insights are illuminating—granting researchers, sexual and reproductive health educators, and policymakers first-person accounts of the psychological experiences associated with national changes in reproductive health policy. Understanding the worries of LGBTQ + people—particularly male-partnered cis bisexual women—can help practitioners orient themselves to the growing concern for access to contraception and abortion and help them to position themselves as advocates for their patients, rather than active or passive gatekeepers of reproductive healthcare.

Future research is needed that expands on our findings and interrogates, for example, the long-term implications of *Dobbs* for people's contraception decision-making and residential mobility. Additionally, attention is needed to how abortion policy shapes individuals' decision-making about family-building and family size. And, research is needed that more fully explores the intersectional nature of individuals' identities—gender identity, sexual orientation, race, and class—and how they impact feelings about and decision-making related to a post-*Roe* world. Providers of abortion care are also providers of other reproductive care, such as prenatal care, gynecologic services, and gender-affirming care (Brandi & Gill, 2023). When providers leave communities because of real or perceived risk of criminalization for providing abortion care, this may result in worse disparities in care for patients overall, but especially for multiply marginalized people (e.g., trans, poor, and of color; Brandi & Gill, 2023; Fredericksen et al., 2023).

Our findings hold important implications for policymakers who work on sexual and reproductive health policy. Policymakers who are committed to advancing reproductive justice and autonomy can draw on our findings to challenge—and establish the potential harm of—national and state policies that infringe on reproductive autonomy. Policymakers can use first-person accounts of the consequences of *Dobbs*, alongside quantitative data, to convey nuanced perspectives of how people across the country are impacted by anti-abortion policies, such as when trying to educate government officials who may lack knowledge of the psychological and social consequences of abortion-hostile policy. Our findings highlight the on-the-ground impact of current reproductive policies for some of the most marginalized and invisible individuals affected by them, and, in turn, highlight the need for more research and advocacy on their behalf.

References

Abaied, J. L., Perry, S. P., Cheaito, A., & Ramirez, V. (2022). Racial socialization messages in white parents' discussions of current events involving racism with their adolescents. *Journal of Research on Adolescence, 32*(3), 863–882. https://doi.org/10.1111/jora.12767

Agénor, M., Murchison, G., Najarro, J., Grimshaw, A., Cottrill, A., Janiak, E., Gordon, A., & Charlton, B. (2021). Mapping the scientific literature on reproductive health among transgender and gender diverse people: A scoping review. *Sexual and Reproductive Health Matters, 29*(1), 57–74. https://doi.org/10.1080/26410397.2021.1886395

Biggs, M. A., Brown, K., & Foster, D. G. (2020). Perceived abortion stigma and psychological well-being over five years after receiving or being denied an abortion. *PLoS ONE, 15*(1), e0226417. https://doi.org/10.1371/journal.pone.0226417

Bostwick, W. B., Hughes, T. L., & Everett, B. (2015). Health behavior, status, and outcomes among a community-based sample of lesbian and bisexual women. *LGBT Health, 2*, 121–126. https://doi.org/10.1089/lgbt.2014.0074

Brandi, K., & Gill, P. (2023). Abortion restrictions threaten all reproductive health care clinicians. *Opinions, Ideas, and Practice, 113*(4), 384–385. https://ajph.aphapublications.org/doi/https://doi.org/10.2105/AJPH.2023.307239

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research*. Sage.

Byers, E. S., & Rehman, U. S. (2014). Sexual well-being. In D. Tolman, L. Diamond, J. Bauermeister, W. George, J. Pfaus, & L. Ward (Eds.) *APA handbook of sexuality and psychology, vol. 1* (pp. 317–337). APA. https://doi.org/10.1037/14193-011

Centers for Disease Control. (2023, January 10). *National health statistics reports*. https://www.cdc.gov/nchs/data/nhsr/nhsr179.pdf

Charlton, B. (2022, August 15). Abortion restrictions harm LGBTQ people now. *Ms. Magazine*. https://msmagazine.com/2022/08/15/abortion-lgbtq-rights-gay-marriage-dobbs-supreme-court/

Charlton, B. M., Hatzenbuehler, M. L., Jun, H. J., Sarda, V., Gordon, A. R., Raifman, J. R. G., & Austin, S. B. (2019). Structural stigma and sexual orientation-related reproductive health disparities in a longitudinal cohort study of female adolescents. *Journal of Adolescence, 74*, 183–187. https://doi.org/10.1016/j.adolescence.2019.06.008

Charlton, B. M., Everett, B. G., Light, A., Jones, R. K., Janiak, E., Gaskins, A. J., Chavarro, J. E., Moseson, H., Sarda, V., & Austin, S. B. (2020). Sexual orientation differences in pregnancy and abortion across the lifecourse. *Women's Health Issues, 30*(2), 65–72. https://doi.org/10.1016/j.whi.2019.10.007

Choi, A. (2023, April 6). Record number of anti-LGBTQ bills have been introduced this year. *CNN*. https://www.cnn.com/2023/04/06/politics/anti-lgbtq-plus-state-bill-rights-dg/index.html

Cohen, C., Wilson, B., & Conron, K. (2022). The implications of Dobbs on reproductive health care access for LGBTQ people who can get pregnant. *The Center on Reproductive Health, Law, and Policy*. https://escholarship.org/content/qt305068m0/qt305068m0.pdf

Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (3rd ed.). Sage.

Cyr, J., & Holder, R. H. (2022). Simultaneous attacks on abortion and LGBTQ rights are not coincidental. *WBUR*. https://www.wbur.org/cognoscenti/2022/04/26/abortion-rights-lgbtq-rights-roe-vs-wade-julian-cyr-rebecca-hart-holder

Dawson, R., & Leong, T. (2020). Not up for debate: LGBTQ people need and deserve tailored sexual and reproductive health care. *Guttmacher Institute*. https://www.guttmacher.org/article/2020/11/not-debate-lgbtq-people-need-and-deserve-tailored-sexual-and-reproductive-health

Dench, D., Pineda-Torres, M., & Myers, C. (2023, November). The effects of the Dobbs decision on fertility. Discussion Paper Series, *IZA Labor Institute of Economics*. https://docs.iza.org/dp16608.pdf

Diamond, L., & Alley, J. (2022). Rethinking minority stress: A social safety perspective on the health effects of stigma in sexually-diverse and gender-diverse populations. *Neuroscience and Biobehavioral Reviews, 138*, 104720. https://doi.org/10.1016/j.neubiorev.2022.104720

Dickey, M., Mosley, E., Clark, E., Cordes, S., Lathrop, E., & Haddad, L. (2022). "They're forcing people to have children that they can't afford": A qualitative study of social support and capital among individuals receiving an abortion in Georgia. *Social Science & Medicine, 315*. https://doi.org/10.1016/j.socscimed.2022.115547

Dobbs v. Jackson Women's Health Organization, 597 U.S. 215 (2022). https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf

Dyar, C., Feinstein, B. A., & London, B. (2014). Dimensions of sexual identity and minority stress among bisexual women: The role of partner gender. *Psychology of Sexual Orientation and Gender Diversity, 1*, 441–451. https://doi.org/10.1037/sgd0000063

Everett, B. G., McCabe, K. F., & Hughes, T. (2017). Sexual orientation disparities in mistimed and unwanted pregnancy among adult women. *Perspectives on Sexual and Reproductive Health, 49*(3), 157–165. https://doi.org/10.1363/psrh.12032

Everett, B. G., Limburg, A., McKetta, S., & Hatzenbuehler, M. L. (2022). State-level regulations regarding the protection of sexual minorities and birth outcomes: Results from a population-based cohort study. *Psychosomatic Medicine, 84*(6), 658–668. https://doi.org/10.1097/PSY.0000000000001092

Fischer, S., Royer, H., & White, C. (2018). The impacts of reduced access to abortion and family planning services on abortions, births, and contraceptive purchases. *Journal of Public Economics, 167*, 43–68. https://doi.org/10.1016/j.jpubeco.2018.08.009

Flanders, C., Gibson, M., Goldberg, A. E., & Ross, L. E. (2016). Postpartum depression among visible and invisible sexual minority women: A pilot study. *Archives of Women's Health, 19*, 299–305. https://link.springer.com/article/https://doi.org/10.1007/s00737-015-0566-4

Foster, D. G., Biggs, M. A., Raifman, S., Gipson, J., Kimport, K., & Rocca, C. H. (2018a). Comparison of health, development, maternal bonding, and poverty among children born after denial of abortion vs after pregnancies subsequent to an abortion. *JAMA Pediatrics, 172*, 1053–1060. https://doi.org/10.1001/jamapediatrics.2018.1785

Foster, D. G., Biggs, M. A., Ralph, L., Gerdts, C., Roberts, S., & Glymour, M. M. (2018b). Socioeconomic outcomes of women who receive and women who are denied wanted abortions in the United States. *American Journal of Public Health, 198*, 407–413. https://doi.org/10.2105/AJPH.2017.304247

Fredericksen, B., Ranji, U., Gomez, I., & Salganicoff, A. (2023). A national survey of OBGYNs' experiences after Dobbs. *Women's Health Policy*. https://www.kff.org/womens-health-policy/report/a-national-survey-of-obgyns-experiences-after-dobbs/

Gessner, M., Bishop, M. D., Martos, A., Wilson, B. D. M., & Russell, S. T. (2020). Sexual minority people's perspectives of sexual health care: Understanding minority stress in sexual health settings. *Sexuality Research and Social Policy, 17*(4), 607–618. https://doi.org/10.1007/s13178-019-00418-9

Goldberg, A. E., & Abreu, R. (2023). LGBTQ parent concerns and parent–child communication about the Parental Rights in Education Bill ("Don't Say Gay") in Florida. *Family Relations, 72*(5), 1–22. https://doi.org/10.1111/fare.12894

Goldberg, A. E., & Allen, K. R. (2015). Communicating qualitative research: Some practical guideposts for scholars. *Journal of Marriage and Family, 77*(1), 3–22. https://doi.org/10.1111/jomf.12153

Goldberg, A. E., Moyer, A. M., Weber, E. R., & Shapiro, J. (2013). What changed when the gay adoption ban was lifted?: Perspectives of lesbian and gay parents in Florida. *Sexuality Research & Social Policy, 10*, 110–124. https://doi.org/10.1007/s13178-013-0120-y

Goldberg, A. E., Smith, J. Z., & Ross, L. E. (2020). Postpartum depression and anxiety in male-partnered and female-partnered sexual minority women: A longitudinal study. In H. Liu, C. Reczek, & L. Wilkinson (Eds.) *Marriage and health: The well-being of same-sex couples*. Rutgers University Press. https://doi.org/10.2307/j.ctv128fqjw.9

Goldberg, A. E., McCormick, N., Kironde, E., Virginia, H., & Logan, M. (2022). White parents of adopted Black children in an era of racial reckoning: Challenges, tensions, and strategies. *Journal of Marriage & Family, 84*, 1–27. https://doi.org/10.1111/jomf.12867

Grossman, D., Joffe, C., Kaller, S., Kimport, K., Kinsey, E., Lerma, K., Morris, N., & White, K. (2023). Care post-Roe: Documenting cases of poor-quality care since the Dobbs decision. *Advancing New Standards in Reproductive Health*. https://psnet.ahrq.gov/issue/care-post-roe-documenting-cases-poor-quality-care-dobbs-decision

Guttmacher Institute (2023, December 13). Interactive map: US Abortion policies and access after Roe. *Guttmacher Institute*. https://states.guttmacher.org/policies/

Hatzenbuehler, M., & Link, B. (2014). Introduction to special issues on structural stigma and health. *Social Science & Medicine, 103*, 1–6. https://doi.org/10.1016/j.socscimed.2013.12.017

HealthCare.Gov. (2023). Federal poverty level (FPL). *Health Care.Gov*. https://www.healthcare.gov/glossary/federal-poverty-level-fpl/

Januwalla, A., Goldberg, A. E., Flanders, C. E., Yudin, M. H., & Ross, L. E. (2019). Reproductive and pregnancy experiences of diverse sexual minority women: A descriptive exploratory study. *Maternal and Child Health Journal, 23*, 1071–1078. https://link.springer.com/article/https://doi.org/10.1007/s10995-019-02741-4

Jones, R. K., Jerman, J., & Charlton, B. M. (2018). Sexual orientation and exposure to violence among U.S. patients undergoing abortion. *Obstetrics and Gynecology, 132*(3), 605–611. https://doi.org/10.1097/AOG.0000000000002732

Jozkowski, K. N., Bueno, X., Turner, R. C., Crawford, B. L., & Lo, W. J. (2023). People's knowledge of and attitudes toward abortion laws before and after the *Dobbs v. Jackson* decision. *Sexual and Reproductive Health Matters, 31*(1), 2233794. https://doi.org/10.1080/26410397.2023.2233794

Kazyak, E. (2015). The law's the law, right?" Sexual minority mothers navigating legal inequities and inconsistencies. *Sexuality Research & Social Policy, 12*, 188–201. https://doi.org/10.1007/s13178-015-0184-y

Kimport, K., & Rasidjan, M. P. (2023). Exploring the emotional costs of abortion travel in the United States due to legal restriction. *Contraception*https://doi.org/10.1016/j.contraception.2023.109956

Kirstein, M., Dreweke, J., Jones, R. K., & Philbin, J. (2022). 100 days post-Roe: At least 66 clinics across 15 US states have stopped offering abortion care. *Policy Analysis*. https://www.guttmacher.org/2022/10/100-days-post-roe-least-66-clinics-across-15-usstates-have-stopped-offering-abortion-care

Kirubarajan, A., Barker, L. C., Leung, S., Ross, L. E., Zaheer, J., Park, B., Abramovich, A., Yudin, M. H., & Sing Hong Lam, J. (2022). LGBTQ2S+ childbearing individuals and perinatal mental health: A systematic review. *Obstetrics and Gynaecology*https://doi.org/10.1111/1471-0528.17103

Klein, J., & Gruberg, S. (2023, July 11). Bans on abortion and gender-affirming care harm the LGBTQ+ community. *National Partnership for Women and Families*. https://nationalpartnership.org/bans-abortion-gender-affirming-care-harm-lgbtq-community/

Klittmark, S., Malmquist, A., Karlsson, G., Ulfsdotter, A., Grundström, H., & Nieminen, K. (2023). When complications arise during birth: LBTQ people's experiences of care. *Midwifery, 121*, 103649. https://doi.org/10.1016/j.midw.2023.103649

Lerma, K., Nagle, A., Strelitz-Block, E., Sierra, G., & White, K. (2023). Perceptions of abortion legality and availability in Mississippi before the fall of Roe. *Sexuality Research and Social Policy, 10*(3). https://doi.org/10.1007/s13178-023-00897-x

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Makleff, S., Blaylock, R., Ruggiero, S., Key, K., Chandrasekaran, S., & Gerdts, C. (2023). Travel for later abortion in the USA: Lived experiences, structural contributors and abortion fund support. *Culture, Health & Sexuality, 25*(12), 1741–1757. https://doi.org/10.1080/13691058.2023.2179666

Mane, H., Yue, X., Yu, W., Doig, A. C., Wei, H., Delcid, N., Harris, A. G., Nguyen, T. T., & Nguyen, Q. C. (2022). Examination of the public's reaction on Twitter to the over-turning of Roe v Wade and Abortion Bans. *Healthcare Journal, 10*(12), 2390. https://doi.org/10.3390/healthcare10122390

Mann, L., Tanner, A. E., Sun, C., Erausquin, J., Simán, F., Downs, M., & Rhodes, S. (2016). Listening to the voices of Latina women: Sexual and reproductive health intervention needs and priorities in a new settlement state in the United States. *Health Care for Women International, 37*(9), 979–994. https://doi.org/10.1080/07399332.2016.1174244

Mitchell, K. R., Lewis, R., O'Sullivan, L., & Fortenberry, J. (2021). What is sexual wellbeing and why does it matter for public health? *Lancet Public Health, 6*(8), 608–613. https://doi.org/10.1016/S2468-2667(21)00099-2

Morrow, S. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250–260. https://psycnet.apa.org/doi/https://doi.org/10.1037/0022-0167.52.2.250

Mosley, E., Redd, S., Lemon, E., Hartwig, S., Narasimhan, S., Berry, E., Lathrop, E., Haddad, L., Rochat, R., Cwiak, C., & Hall, K. (2022). Racial/ethnic differences in the effects of Georgia's 22-week gestational age limit on abortion incidence and ratios. *Women's Health Issues, 32*, 9–19. https://doi.org/10.1016/j.whi.2021.09.005

Movement Advancement Project (2019). Where we call home: LGBT families in rural America. *Movement Advancement Project*. https://www.lgbtmap.org/about-map/rural-lgbt-family

Nandagiri, R., Coast, E., & Strong, J. (2020). COVID-19 and abortion: Making structural violence visible. *International Perspectives in Sexual and Reproductive Health, 46*(1), 83–89. https://doi.org/10.1363/46e1320

New York Times. (2023, October 13). Tracking abortion bans around the country. *New York Times*. https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html

Odum, T., Heymann, O., Turner, A. N., Rivlin, K., & Bessett, D. (2023). Assessing psychosocial costs: Ohio patients' experiences seeking abortion care. *Contraception, 117*, 45–49. https://doi.org/10.1016/j.contraception.2022.08.007

Pavan, E. (2020). We are family: The conflict between conservative movements and feminists. *Contemporary Italian Politics, 12*(2), 243–257. https://doi.org/10.1080/23248823.2020.1744892

Peitzmeier, S., Khullar, K., Reisner, S., & Potter, J. (2014). Pap test use is lower among female-to-male patients than non-transgender women. *American Journal of Preventive Medicine, 47*(6), 808–812. https://doi.org/10.1016/j.amepre.2014.07.031

Porsch, L., Zhang, H., Paschen-Wolff, M., Grosskopf, N., & Grov, C. (2020). Contraceptive use by women across multiple components of sexual orientation: Findings from the 2011–2017 National Survey of Family Growth. *LGBT Health, 7*(6), 321–331. https://doi.org/10.1089/lgbt.2020.0013

Radis, B., & Nadan, Y. (2021). "Always thinking about safety": African American lesbian mothers' perceptions of risk and well-being. *Family Process, 60*(3), 950–965. https://doi.org/10.1111/famp.12607

Rao, S., Mason, C. D., Galvao, R. W., Clark, B. A., & Calabrese, S. K. (2020). "You are illegal in your own country": The perceived impact of antisodomy legislation among Indian sexual and gender minorities. *Stigma and Health, 5*(4), 451–462. https://psycnet.apa.org/doi/https://doi.org/10.1037/sah0000218

Reynolds, C. A., & Charlton, B. M. (2021). Sexual behavior and contraceptive use among cisgender and gender minority college students who were assigned female at birth. *Journal of Pediatric & Adolescent Gynecology, 34*(4), 477–483. https://doi.org/10.1016/j.jpag.2021.03.009

Reynolds, C. A., & Charlton, B. M. (2022). Pregnancy prevention and unintended pregnancy across gender identity: A cross-sectional study of college students. *Sexual Health, 18*(5), 441–443. https://doi.org/10.1071/SH21103

Ross, L. E., Goldberg, J. M., Flanders, C. E., Goldberg, A. E., & Yudin, M. H. (2018). Bisexuality: The invisible sexual orientation in sexual and reproductive health care. *Journal of Obstetrics and Gynaecology Canada, 40*(8), 1057–1060. https://doi.org/10.1016/j.jogc.2018.02.022

Skuster, P., & Moseson, H. (2022). The growing importance of self-managed and telemedicine abortion in the United States: Medically safe, but legal risk remains. *American Journal of Public Health, 112*(8), 1100–1103. https://doi.org/10.2105/AJPH.2022.306908

Smith, C., & George, R. (2021, July). Bisexual women's invisibility in health care. *AMA Journal of Ethics*. https://journalofethics.ama-assn.org/article/bisexual-womens-invisibility-health-care/2021-07

Tabaac, A., Sutter, M., Haneuse, S., Agénor, M., Bryn Austin, S., Guss, C., & Charlton, B. (2022). The interaction of sexual orientation and provider-patient communication on sexual and reproductive health in a sample of U.S. women of diverse sexual orientations. *Patient Education & Counseling, 105*(2), 466–473. https://doi.org/10.1016/j.pec.2021.05.022

Thornton, M., & Arora, K. S. (2023). Reproductive justice in post-Roe America: Impact of restricted abortion access on patients seeking permanent contraception. *Contraception.*https://doi.org/10.1016/j.contraception.2023.109995

US Department of Health & Human Services (2022). *Know your rights: Reproductive health care*. https://www.hhs.gov/about/news/2022/06/25/know-your-rights-reproductive-health-care.html

Wilson, B. D. M., Gordon, A. R., Mallory, C., Choi, S. K., Badgett, M. V. L., & LBQ Women's Report Team. (2021). Health and socioeconomic well-being of LBQ women in the U.S. *The Williams Institute*.

Wilson, B. D. M., Bouton L. J. A., Badgett, M. V. L., Macklin, M. L. (2023). LGBTQ poverty in the United States. *The Williams Institute*. https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Poverty-COVID-Feb-2023.pdf

Yildiz, H. (2015). The relation between pre-pregnancy sexuality and sexual function during pregnancy and the postpartum period: A prospective study. *Journal of Sex & Marital Therapy, 41*(1), 49–59. https://doi.org/10.1080/0092623X.2013.81145