Published in final edited form as:

Soc Work Health Care. 2020 March ; 59(3): 180–198. doi:10.1080/00981389.2020.1737304.

Pregnancy (im)possibilities: identifying factors that influence sexual minority women's pregnancy desires

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Abstract

Sexual minority women (SMW) face both increased risk for unintended pregnancy and barriers to achieving wanted pregnancy, but little research investigates SMW's pregnancy desires. To fill this gap, we conducted five focus groups and 11 in-depth interviews with 20–30-year-old SMW in three US cities. Findings highlight that the heteronormative pregnancy planning paradigm lacks salience for SMW. While some SMW clearly wish to avoid pregnancy, many others are unsure, and factors influencing this uncertainty include relationship context, anticipating logistical barriers, and discord between queer identity and pregnancy.

Keywords

LGBQ+; sexual minority women; reproductive health; pregnancy desires; qualitative

Introduction

Sexual minority women (SMW), or women[1] who identify as lesbian, bisexual, queer, or other non-heterosexual identities experience both wanted and unwanted pregnancies. A growing body of research documents that SMW are at an increased risk of unwanted or mistimed pregnancies compared to their heterosexual peers (Everett et al., 2017; Stoffel et al., 2017). Conversely, SMW simultaneously face barriers to achieving wanted pregnancies,

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Disclosure statement

The authors have no disclosures.

1.For the purposes of this paper, "woman" refers to cisgender women. That is, women who were assigned female at birth and identify as women.

such as difficulty accessing artificial reproductive technologies, financial barriers, and discrimination and homophobia in the health system (Chapman et al., 2012; Hayman et al., 2015; Renaud, 2007).

To date, much of the research on SMW's pregnancy intentions and experiences focuses on SMW's use of assisted reproductive technologies (ARTs) to achieve highly desired pregnancies. While important, this research only includes women who already have clear pregnancy desires and/or are accessing services to attempt pregnancy. Little is known about SMW's pregnancy intentions or plans for future children outside of those that seek fertility treatments. We also know little about the pregnancies desires of SMW who are currently at risk of unintended pregnancies, including SMW who may be ambivalent about whether they want to be pregnant or not. Studying a diverse range of women with differing future pregnancy desires recognizes the complexity in family formation for sexual minority individuals and is an important step in promoting reproductive justice for SMW.

Social workers play a critical role in supporting reproductive health (Begun et al., 2016; Bird et al., 2016), specifically for individuals, families, and communities who face financial, legal, and other barriers to achieving their reproductive health goals. This goal is central to the code of ethics and values of the social work profession. In fact, the National Organization of Social Workers (NASW), released a professional statement calling for reproductive choice and for reproductive health services to be "legally, economically and geographically accessible to all who need them" (NASW, 2009, p. 129). In order to support SMW in reproductive choice and accessing appropriate family planning services, social work practitioners and researchers in conjunction with reproductive health providers require a deeper understanding of the unique pregnancy-related experiences of SMW.

Pregnancy and SMW

Pregnancy is a common experience for women of all sexual identities. An analysis of data from the Women's Health Initiative estimated that 35% of lesbians and 81% of bisexual women experienced at least one pregnancy in their lifetime (Valanis et al., 2000). Other studies estimate to be the number of SMW who have had at least one pregnancy to be roughly 37% among SMW broadly (Everett et al., 2016; Marrazzo & Stine, 2004). Studies that have documented that abortion is common for SMW (Hodson et al., 2017; Jones et al., 2018; Marrazzo & Stine, 2004). Research in this area is beginning to document some of the possible sources of this disparity. For example, the health system may play a role, as queer women are less likely to access, use, or be offered reproductive health and family planning services (Tornello et al., 2014). Community norms and sexual scripts may also play a role in the likelihood of using contraception (Power et al., 2009). Finally, structural factors contribute to this disparity, as queer women are more likely to be uninsured or low income (Buchmueller & Carpenter, 2010). Cumulatively, these findings suggest that SMW commonly experience both wanted and unwanted pregnancies.

Much of what is known about pregnancy and pregnancy-related experiences among SMW involves experiences with ART and related healthcare. SMW in same-sex relationships have specific concerns related to ART, such as which partner will carry the pregnancy, whether or not to use a known donor, and which ART methods they want or can afford to use (Hayman

et al., 2015). Existing literature also documents the barriers SMW face to achieving highly desired pregnancies. These barriers include discrimination and homophobia while seeking ART (Chapman et al., 2012) as well as financial concerns. Pregnancy intentions outside the context of ARTs among SMW are largely unknown.

In line with patterns of disparities in unintended pregnancy among marginalized women, evidence suggests that SMW experience higher rates of unintended pregnancies than heterosexual women across the reproductive life course (Everett et al., 2017; Charlton et al., 2013; Dehlendorf et al., 2010; Finer & Zolna, 2014; Saewyc, 2014; Ybarra et al., 2016). Recent evidence indicates that adolescent SMW, especially bisexual adolescents, are at greater risk of experiencing an unintended pregnancy than are heterosexual adolescents (Goldberg et al., 2016; Saewyc, 2011). Higher rates of unintended, and specifically, unwanted pregnancies among SMW may also persist into adulthood. As many as one in four adult SMW have experienced an unintended pregnancy (Everett et al., 2016; Marrazzo & Stine, 2004). Adult SMW are more likely to report pregnancies as mistimed or unwanted, and bisexual and heterosexual women who have sex with women report lower mean happiness about their pregnancies than heterosexual women with only male partners (Everett et al., 2017). Despite compelling epidemiologic evidence of disparities in unplanned pregnancy rates, to date, little research has documented the pathways that lead to this disparity. In particular, little research has documented women's complex thoughts about and desires for pregnancy, particularly how SMW frame pregnancies that have already happened, including among SMW who engage in the type of sex that could lead to pregnancy.

Pregnancy intention as a debated concept

Pregnancy intention has been used as an indicator of population-level reproductive health since it first emerged as a concept in the United States after World War II (Santelli et al., 2003). For decades, researchers have defined unintended pregnancy as a pregnancy that is reported as either *unwanted* (wanted at no time) or *mistimed* (happened sooner than a woman would have ideally wanted) (Finer & Zolna, 2016). However, a now vast literature critiques the concept of unintended pregnancy, arguing that neither intendedness nor wantedness may be salient constructs for individuals. Many pregnancies are neither wholly intended nor wholly unintended, instead representing a variety of experiences between two ends of a spectrum, including uncertainty or ambivalence about pregnancy (Santelli et al., 2003). Forms of pregnancy ambivalence may include fatalistic ideas about pregnancy, wanting a pregnancy to happen without planning, or misaligned pregnancy desires and contraceptive behaviors (Aiken, 2015; Aiken et al., 2016; Borrero et al., 2015; Higgins et al., 2012). Alternative constructs to pregnancy intention include pregnancy acceptability, or how well an individual accepts a pregnancy, and reproductive autonomy, or the extent with which individuals feel control over their reproductive choices (Aiken et al., 2016; Dehlendorf et al., 2018). Despite the richness of this literature, researchers have yet to explicitly examine the role of sexual identity in their investigations in shaping women's pregnancy desires and experiences.

In order to support SMW in meeting their reproductive health goals – whether that be to achieve or avoid pregnancy – we need a better understanding of how SMW frame

pregnancies in the context of their lives and identities. This study fills this gap by examining how sexual identity may influence or shape pregnancy desire. The current analysis aims to document how SMW describe their pregnancy desires, particularly the extent to which those desires might influence contraceptive use.

Materials and methods

Overview

Data for this analysis derive from a study of young adult SMW and contraceptive contexts in three cities: Chicago, Illinois; Salt Lake City, Utah; and Madison, Wisconsin. We selected the 20–30-year-old age group given prior studies' focus on adolescent SMW's experiences with contraception and unintended pregnancy, as 20–30-year-olds carry a disproportionate burden of unintended pregnancies (Everett et al., 2017; Finer & Zolna, 2014). Recruiting participants in three cities leveraged both team members' locations as well as regional diversity across the sampling frame.

Investigators used a qualitative descriptive approach. Qualitative description maintains the naturalistic philosophy that is essential for exploring understudied topics and generating hypotheses (Creswell, 2003), but uses data to *describe* participants' attitudes and experiences versus trying to build theory or discover the essential structure of a lived experience (Sandelowski, 2010; Willis et al., 2016). Qualitative description is also useful for documenting *personal and social meanings and practices*, which are vital in documenting SM women's experiences with contraception and the kinds of sex that can lead to pregnancy (Ulin et al., 2002).

In the first phase of data collection, investigators conducted five focus groups with 22 women who identified as queer or something other than heterosexual, were assigned female at birth, and were between the ages of 20 and 30. Focus groups were designed to explore three things: 1) social norms pertaining to the social, cultural, and life-course contexts in which SM women engage in heterosexual relationships, including penile-vaginal intercourse; 2) SM women's attitudes toward contraception, either during or independent of penile-vaginal intercourse, and; 3) effective and ineffective provider interactions with SM women regarding reproductive sexual health. We selected focus groups given their utility in measuring social norms, expectations, and values (versus individual beliefs and experiences) (Ulin et al., 2002). However, we also wanted to more deeply explore the contexts in which SM women engage in the type of sex that can lead to pregnancy. Therefore, in the second part of data collection, we conducted eleven one-on-one interviews with SM women. The purpose of these interviews was to assessing SM women's actual experience (or lack thereof) with contraception within the context of penile-vaginal intercourse they have had in the last year.

Focus groups and interviews took place between August 2017 and April 2018. Prior to any data collection, IRBs at the Universities of Wisconsin-Madison, Chicago, and Utah reviewed and either waived (Wisconsin) or approved (Chicago, Utah) the study design and instruments.

Recruitment and sampling

We recruited women for focus groups primarily via social media (eg. Facebook) using targeted posts in LGBTQ advocacy and social groups. Some participants also referred friends who qualified for the study. To be eligible for participation, women needed to be between the ages of 20 and 30, identify as queer or something other than heterosexual, and have been assigned female at birth. We recruited interview participants through the same channels, but with one additional inclusion criterion: interviewees needed to have engaged in penile-vaginal intercourse at least once in the last year. To establish eligibility, the first author contacted participants and directed them to fill out a brief online survey. If they were eligible for the study, she contacted the participant to enroll them in the study.

Data collection procedures

Focus groups were conducted in person and facilitated by the first author and one member of the study team local to each city. Focus groups took place in conference rooms on campus in each of the respective locations. Focus groups contained between 2 and 7 participants (total N = 23) and lasted between 2 and 2.5 hours. The first author conducted all the interviews. Interviews lasted between 60 and 90 minutes. Four interviewees were from Madison, four from Chicago, and three from Salt Lake City (N = 11). The first author conducted the Madison interviews face-to-face in private community rooms in local libraries; Chicago and Salt Lake City interviews took place on Zoom, an online video conferencing program with recording capabilities.

The study team developed a lengthy semi-structured guide for both focus groups and interviews. At the conclusion of the focus group or interview, each participant received cash or an online gift card credit and, and 5.00 USD in cash to cover transportation costs. All focus groups and interviews were audio-recorded, then transcribed by either a study team member or an independent transcription service. The facilitator or interviewer also wrote up a 1–2-page memo after each focus group or interview, summarizing the session and highlighting particularly relevant themes or stories. These memos became part of the qualitative data analyzed for the project.

Focus groups and interviews focused much more broadly on SMW's experiences with contraception, penile-vaginal intercourse, perceptions of pregnancy risk, and experiences seeking reproductive health care (Greene et al., 2019; Higgins et al., 2019). Focus group questions related to pregnancy included (1) What are SMW's unplanned pregnancy experiences? Abortion experiences? and 2) What would it be like to have an unintended pregnancy in your group of friends or in your community). Interview participants who had experienced an unintended pregnancy were asked: 1) What was happening in your life when you experienced a pregnancy scare/unintended pregnancy? 2) How did you feel about the pregnancy? How did this experience relate to your sexual identity? 3) How did you resolve the unintended pregnancy? 4) How, if at all, did your unintended pregnancy change your approach to contraception? Interview participants who had not experienced an unintended pregnancy were asked about pregnancy scares. All interview participants were also asked: 1) "What would it be like for you to get pregnant right now?" and 2) "How do you feel about getting pregnant at some point in the future?"

Data analysis

The authors used combined inductive and deductive thematic analysis techniques, drawing from preexisting themes from the literature and research aims as well as from the data themselves. Thematic analysis is an analysis technique that allows for identifying and organizing patterns of meaning in a data set and is often used by researchers taking a descriptive approach to the phenomenon under study (Braun & Clarke, 2012).

About halfway through data collection, the first and last authors generated the first-draft codebook of dozens of possible codes based on both the research questions of interest and *in vivo* codes that had arisen during data collection. Input from the third and fifth authors led to codebook edits. Six trained team members then applied codes to the first focus group transcript, both to further refine the codebook and to gain consistency in team members' application of codes. The final codebook contained 28 codes. Two of the original six coders then independently coded each subsequent transcript and met to discuss each code until reaching 100% agreement. One coder per transcript entered all codes into Atlas.ti, a software package for managing and analyzing qualitative data.

For the analysis presented here, investigators relied on the pre-established "pregnancy desires" and "pregnancy experiences" codes. All authors read over the "pregnancy desires" and "pregnancy experiences" coding reports, referred to the associated interview memo when useful, organized data in each coding report in to preliminary themes and sub-themes, and finally met to compare and confirm those themes. Themes and sub-themes became the basis of the results section below.

Results

A total of 33 SMW participated in our study; 22 individuals participated in 5 focus groups and 11 in individual interviews. Table 1 displays the demographic characteristics of the sample. Quotes included below are representations of each theme. All names are pseudonyms chosen by the participants. Three of the women reported having at least one abortion. While a small number (n = 3) of women in the sample wanted to become pregnant in the near future, two other dominant patterns emerged from our data; some participants were clear they did not want to become pregnant and articulated the negative consequences of pregnancy in their lives, while others were unclear about their desire for an immediate or future pregnancy and expressed ambivalence.

Clear desire to avoid pregnancy

For participants who wanted to avoid pregnancy (n = 12), not only were their pregnancy desires clear, but they also anticipated severely negative consequences for their wellbeing if they experienced an unintended pregnancy. Julianna (Queer, 22, Madison-interview) said "I'm not in a financial place in my life, I'm not at an age … I don't want to do that right now." Similarly, Addison (Queer, 24, Chicago-interview) expressed that "[an unplanned pregnancy] would really throw a wrench in a lot of my plans. I'm looking at starting grad school in the fall and I'm subsequently moving. I'm definitely not in the financial position to take care of a kid … So, I think that is one of my worst nightmares." Both of these

participants were clear that they were not in a financial position nor did they want to have children at this point in their lives. While other participants expressed similar sentiments, they also recognized that if they became pregnant, obtaining an abortion may be difficult.

Difficulty of obtaining an abortion

While the participants who expressed a desire to avoid pregnancy also expressed their intention to have an abortion they were concerned about the difficulty of obtaining an abortion, both logistically and emotionally. For example, River (Queer, 26, Salt Lake City-focus group), described watching a friend go through the process of getting an abortion, including the waiting period and mandatory counseling sessions. When asked what it would be like to get pregnant, she said:

> Pretty not great. I've had a close friend go through that before and it definitely ruined her life in a lot of ways. She was able to get an abortion but I know she … she didn't necessarily have any hang-ups about it, but she was definitely really emotional for her to go through. And she didn't have a supportive partner at all. So I feel like for me personally, to have an unintended pregnancy right now. That would pretty much screw up my life in every way. So pretty … pretty negative."

After watching her friend go through this experience, River believed that having an abortion would be a difficult experience, and expressed what a negative impact this process would have on her and on her life. River did not explicitly connect the difficulty of obtaining an abortion to her queer identity but rather focused on the logistical barriers and emotional implications. While many women, regardless of their identity, may need to obtain an abortion, identifying as queer might add an additional layer of difficulty. One participant, Buffy (Pansexual, 21, Salt Lake City-focus group), explained this well when she said:

> It's another layer of something that's already emotionally and financially and logistically difficult. And now it adds this whole other layer of something that is not quite what you identify with. Like if you don't really identify with wanting to have sex with people who could get you pregnant and then you do, it's another thing screwing up your life but you didn't even want the root of it.

While the majority of the participants felt like having an abortion would be logistically and emotionally difficult, some felt more confident in their ability to get an abortion than others. Ashley (Not-straight, 25, Madison-focus group) described being in a place where she was financially and emotionally stable enough to navigate getting an abortion. She said:

> "I think that having an unintended pregnancy would be overall just a really negative experience having to deal with that. But I think for myself, and most friends that I think about, if they were to have an unintended pregnancy now, would get an abortion pretty easily and it wouldn't be a huge, a huge deal."

Mental health implications of unintended pregnancy

Among those strongly motivated to avoid pregnancy, mental health implications of unintended pregnancy weighed heavily on study participants. Several participants felt that getting pregnant before they were ready would negatively impact or destabilize their mental health. In a focus group, other participants echoed the sentiment that their mental health

would be significantly impacted by an unplanned pregnancy. When asked what it would be like to have an unintended pregnancy, one participant, Julianna (Demisexual, 23, Salt Lake City-focus group), said "the thought of being pregnant makes me suicidal. Like it's just really bad." In response, another participant, Bone (bisexual/queer, 25, Salt Lake City-focus group) said she agreed that pregnancy scares "affect [her] mental health more than anything else". Another participant, Rachel (bisexual, 25, Madison-interview,) described a pregnancy scare as a "pregnancy threat" and was extremely worried about what would happen if she became pregnant. For Rachel, even thinking she was pregnant had implications for her anxiety:

> It was just way too close. And I went out and I got a pregnancy test cause I had to just clear my head … But, I started getting really nervous … it was kind of, I'm going to say threat because to me it was the threat of pregnancy.

This feeling was heightened for the participants who had already experienced an unplanned pregnancy. Experiencing another could be seen as potentially traumatic. Vanessa (Queer, 30, Madison-interview), described the thought of getting pregnant again as "terrifying." Vanessa had both attempted to become pregnant with planning and had two previous unplanned pregnancies, one of which was the result of a sexual assault. Her experiences navigating pregnancy and abortion were such an "emotional roller coaster" that she was very clear that she did not want to get pregnant again.

> Every decision I made was to propel me forward to be a mother. And then after I couldn't get pregnant, and then I got pregnant as a result of an assault and had another abortion. That was it for me. I was like "I can't." I rode the emotional roller coaster of pregnancy, abortion, and potential motherhood, and not being able to conceive with a long-term partner. I just, I can't even fathom it at this point anymore.

Echoing these same thoughts, Sofia (Bisexual/queer, 25, Chicago-interview), described the physical symptoms of pregnancy as "triggering in some ways." She believed re-living the same physical symptoms of her unwanted pregnancy would be extremely difficult. For participants that wanted to avoid pregnancy, they were acutely aware of the consequences of unplanned pregnancy and the psychological implications an unintended pregnancy might have on their mental health.

Uncertainty about pregnancy

Other participants were unsure what they wanted in terms of pregnancy or what they would do if they experienced an unintended pregnancy. Some participants described some of the same factors that heterosexual women have cited regarding pregnancy uncertainty, such as their current partnership, financial stability, and life stage (Higgins, 2017; Kraft et al., 2010; Lewin et al., 2014; Tough et al., 2007). However, sexual identity often added unique factors that contributed to ambivalence or uncertainty, such as relationship structure or anticipated conflict with one's queer identity.

Removing the fear of pregnancy allows for deeper consideration of pregnancy desires

Participants spoke about pregnancy considerations that were specific to current relationships with other women. participants described their feelings about pregnancy had shifted because their current relationships with women were healthier and more stable than previous relationships. For example, Beatrice (bisexual, 21, Chicago-focus group), felt her "mentality toward becoming pregnant had done a complete 180" in her current relationship with a woman. Previously, she was not open to pregnancy, but now her perspective toward it had become "wouldn't it be nice if someday this could happen." She credited this shift to now being able to consider her feelings about pregnancy and parenting in the context of a relationship she considered healthy and stable. She also articulated that when in relationships with men, she felt "societal pressure to have children eventually" because she was in "the right context in which to have children." Being in a relationship with a woman, she no longer felt that pressure and therefore became more open to and "welcoming" of the idea of being pregnant.

Relatedly, for others, removing the fear of pregnancy associated with having sex with men allowed them to consider their pregnancy desires more fully. Jo (bisexual/queer,21, Chicago-focus group) described how fear impacted her feelings about pregnancy:

> I've always known I've wanted to have kids but even so, when I was in a long-term relationship with men it's this constant fear and constant paranoia "don't get pregnant, don't get pregnant" even though I want to have kids one day, I want to give birth to several kids but it was, like, crippling fear almost. And now I just feel like great about it, I'm like, 'yeah, babies, pregnancy!' Now that I can't get pregnant. So, it's just a mentality thing.

For Jo, being in a relationship that removed the "crippling fear" of an unintended pregnancy opened her up to positive feelings about pregnancy.

Logistical barriers make pregnancy desires less clear

While some participants described being in a relationship with another woman leading to more interest in pregnancy, many described the logistical and financial barriers to becoming pregnant in a same-sex relationship. Gabriella (Fluid, 27, Madison-focus group) talked about the contrast between being worried about pregnancy and being ready for pregnancy in her current partnership with a woman.

> It's funny to me that I spend so much of my life trying to avoid getting pregnant [laughs]. And now that I'm at an age and at the end of my doc program where I could actually have a baby with my partner, it would require immaculate conception … It's not happening anytime soon.

Despite readiness for pregnancy, the logistical and financial barriers to becoming pregnant as an SMW in a same-sex relationship also influenced feelings about pregnancy. In some cases, these barriers made participants less clear about their pregnancy desires, especially for those in committed partnerships with other cisgender women who could not see a clear path to pregnancy (n = 5). Sofia (bisexual/queer, 25, Chicago-interview) said that the "logistics and the difficulties of pregnancy" made her "more hesitant" to try to get pregnant. She was not

clear if she wanted to have children or get pregnant herself, but the barriers weighed heavily on her mind:

> If I do end up with a cisgender woman, it's going to be so much more complicated getting pregnant … probably really expensive too. And so that's another consideration …. and that makes me worry.

Similarly, Heather (lesbian, 29, Madison-focus group) described feeling unclear about how she would respond to an unintended pregnancy, in part due to the barriers to intentional or planned pregnancy When asked what it would be like to get pregnant right now, the only way she could imagine this happening was through sexual assault. She said she "would have had to have been too drunk to consent or … would have to have been attacked in some way." However, Heather described herself as "completely ambivalent" about such an unplanned pregnancy, partially due to the perceived difficulty in becoming pregnant intentionally with her spouse and her emerging readiness to parent. She continued:

> I'm 29 and I'm married and we have double incomes and we're at a point where we have talked about [having] kids or not. So, I think if I got pregnant when I was younger unintentionally, I would have had an abortion no question. But now that we're at the age where we are talking about if we want kids, how are we going to do it? Are we going to adopt? That's super expensive and takes a long time. Will we use artificial insemination or IVF? Again, super expensive and time-consuming. I was sitting here thinking about it for the first time, and I was like 'Oh my gosh, I might consider keeping that pregnancy.'"

Even envisioning a future pregnancy from this terrible circumstance, the barriers to a planned pregnancy were enough to make Heather unsure what she would do if she became pregnant.

Discord between queer identity and pregnancy

Regardless of specific partnerships or identities, participants expressed a nearly universal tension between being queer and their feelings about pregnancy. In addition to being logistically complicated, pregnancy may or may not fit into what it means to be queer. Some expressed concern that pregnancy was a "straight thing" (Daisy, pansexual, 21, Salt Lake City-Interview). One interviewee, Daisy (Pansexual, 20, Salt Lake City-interview), highlighted how painful it was to "feel left out the process" of pregnancy and family making due to heteronormative narratives about pregnancy. These narratives were described as both social norms imposed onto queer individuals and internalized beliefs.

> I think that pregnancy is a really hard thing for queer people. I mean that's something that I used to cry about and freak out about. If I'm a lesbian, do I get to have a child? Will I ever get to carry a child and feel like I have a child that's really mine? And that's something that I worried about a lot was the fact the pregnancy is a very straight thing … So there's a lot of complications around child-rearing that happen in queer communities that don't happen in a hetero, normal relationship … I think that pregnancy is a little bit of a sore spot.

Pregnancy may or may not be acceptable in the LGBTQ+ community. One participant, Addison (Queer, 26, Chicago-interview), said that pregnancy "just wasn't part of [the queer community's] cultural narrative." There was some recognition that how one became pregnant would determine the acceptability of the pregnancy in participants' queer communities. Logan (Lesbian, 25, Chicago-interview) explained that a pregnancy resulting from ART would be accepted, but a pregnancy resulting from having sex with a man would not be accepted by her community. Participants discussed what pregnancies – both intended and unintended – might mean for their identity or their ability to fit into their communities.

Participants in relationships with men seemed to be especially concerned that getting pregnant would delegitimize their queer identity. Because these women often felt invisible or left out of the queer community, "[pregnancy] further compounds the kind of tension that can exist for queer, femme women who are in relationships with cis men" (Helen, queer femme, 29, Salt Lake City-interview). Another participant, Buffy (Pansexual, 21, Salt Lake City-focus group), described feeling similarly:

> I feel like for me, I don't really identify with the whole nuclear family thing. With the mom and the dad and the kid and that stuff. I feel like the idea of getting pregnant and locked into this weird heterosexual cis-normative thing, just freaks me out. I don't want to be sealed in … I feel like if I got pregnant, that would shut a door on me. Even though I know that's not true and I have options … I feel like mentally it would seal that for me, which would be difficult.

While considering if she wanted a pregnancy, Buffy and others also had to consider if they could tolerate the erasure of queer identity that would follow.

Discussion

This study aimed to examine how sexual identity may influence or shape pregnancy desire among a sample of young SMW. Just as we were originally motivated to document the pathways to disparity in unintended pregnancy, much of the nascent reproductive health research regarding SMW has been motivated by disparities in health outcomes, including an elevated risk of unintended pregnancy among SMW (Everett et al., 2017). Results from this study offer a more nuanced understanding of unintended pregnancy among SMW and the unique ways that queerness challenges the traditional pregnancy planning paradigm.

While not all of our participants desired to avoid pregnancy (n = 12), the strength with which some participants described the consequences of an unintended pregnancy cannot be discounted. Describing an unwanted pregnancy as "destabilizing" or a "threat", emphasizes that access to abortion and contraception access abortion are just as crucial for SMW as for heterosexual women. Additionally, queer identity may make obtaining an abortion more difficult or amplify the implications of an unwanted pregnancy. There are documented disparities in reproductive health care utilization, including contraceptive use, for SMW, and there is evidence that reproductive health care may not be meeting the needs of SMW (Everett et al., 2018). Our findings highlight the need for appropriate and inclusive family planning services, especially given SMW's increased risk of unwanted or mistimed

pregnancy Future studies should further explore queer-specific reasons for wanting to avoid pregnancy.

However, for other participants, uncertainty and ambivalence about pregnancy were just as salient. This study uncovered a variety of *queer-specific factors* that shape SMW's ambivalence. For women expecting to be in long-term relationships with other cisgender women, barriers to pregnancy played a significant role in shaping their ideas about pregnancy. Many viewed pregnancy as inaccessible, worried about the logistical complications and expense of pregnancy. Just as structural factors are important drivers of reproductive health disparities among other marginalized women, they play an important role for SMW (Borrero et al., 2009). While previous literature suggests that these considerations shape the process of becoming pregnant, our results suggest that the barriers may also be a deterrent from seeking (otherwise desired) pregnancies (Renaud, 2007).

The heteronormativity that surrounds pregnancy and family planning discourses impacts whether or not participants thought pregnancy was an option for them (Mamo, 2007). Historically, lesbians may not have viewed motherhood as an option (Hayman et al., 2015) Our results highlight the way that heteronormativity around not just motherhood, but pregnancy itself may be also internal, such as viewing pregnancy as a "straight thing" or worrying that pregnancy might erase their queer identity. There may also be external pressures as lesbians and other SMW are likely to experience stigma or discrimination while seeking health services (Gregg, 2018; Chapman et al., 2012).

In a recent study exploring reproductive health needs among LGBTQ+ individuals assigned female at birth, participants themselves said that researchers should pursue research on family formation and pregnancy-specific to LGBTQ+ individuals (Wingo et al., 2018). In previous research regarding pregnancy in the context of ARTs, Hayman et al. (2015) identified the unique ways that identity plays into discussions about pregnancy between two partners (Hayman et al., 2015). Our results suggest that there are additional identity-related considerations for SMW – both in and outside of a relationship context – before even the initial steps to seek pregnancy. Given the unique needs of SMW, pregnancy planning concepts central to the family planning field including unintended pregnancy, and emerging concepts such as pregnancy or reproductive autonomy, should be broadened to include the role of queer identity.

Limitations

Findings should be considered in light of study limitations. First, the study sample was relatively economically and racially privileged. The majority of the participants were white, and roughly three-fourths of the sample had a college degree or were in the process of completing one. Future studies should include a more diverse sample so knowledge in this area is intersectional and based on racially and economically diverse perspectives. Second, this study was limited to three urban geographical areas in the United States. Women in other areas, especially areas less accepting of LGBTQ+ individuals, may have different experiences and desires for pregnancy. Finally, the aims of the original study were not specific to pregnancy desires and planning, and thus, more questions emerged than were answered by the data.

Connections to social work research and practice

Findings from this study have implications for both social work research and practice. Social workers play a crucial role in promoting reproductive health and wellbeing through individual and community practice, program implementation, and policy advocacy. Social workers have a unique skill set that can help ensure that marginalized identities are not further overlooked or underrepresented in reproductive health-related work (Begun et al., 2016; Bird et al., 2016). Findings from this study further social work research by providing a nuanced understanding of SMW's pregnancy desires. Specifically, social workers involved in mental health care or counseling may wish to assess pregnancy desires to support their clients in avoiding a pregnancy that may be destabilizing to their mental health or pursuing their pregnancy desires in the context of negative peer pressure or stigma. Additionally, social workers in healthcare delivery settings can play a role in supporting clients in achieving a wanted pregnancy in the context of structural and financial barriers. Finally, social workers can advocate more broadly for systems and policies to promote appropriate, accessible, and affordable, and trauma-informed reproductive health care for SMW.

This study also has implications for family planning and reproductive health care providers. Family planning providers should avoid assumptions about pregnancy desire based on sexual identity and assist queer patients in choosing reproductive health care, including contraception, abortion, fertility planning, or ART that is in line with their reproductive health care and family planning priorities. Seeking pregnancy prevention and abortion services can be difficult for women of all identities to access; but, accessing compassionate and inclusive services may be especially difficult for SMW (Everett et al., 2017). Additionally, participants described unintended pregnancies as potentially "triggering" either past negative experiences with pregnancy or mental health concerns. Especially given higher rates of sexual violence among SMW, family planning services should adopt standards of trauma-informed care (Jones et al, 2018; Elliott et al., 2005). Future research should seek to clarify what constitutes inclusive and compassionate contraception and abortion care for SMW and how to successfully implement it. Our participants viewed pregnancy as inaccessible and were worried about the logistical complications and expense of pregnancy. Improving access and reducing cost-barriers to the full range of family planning services is crucial to supporting all individuals in their reproductive health goals, including sexual minority women.

Conclusion

This study fills important gaps in previous literature. While a now robust body of literature on pregnancy intention has expanded on concepts such as unintended pregnancy among heterosexual women, this study adds to this work by specifically examining pregnancy intention or desire in the context of SMW's lives. Our study also looks at pregnancy beyond the context of ART and includes a range of SMW identities. Understanding SMW's pregnancy desires and the factors informing their desires is essential to creating reproductive health care services that are inclusive of SMW's unique needs and experiences.

Acknowledgments

The authors gratefully acknowledge the Society for Family Research Fund for supporting this study (SFPRF11-II3, SFPRF10-II3). Jenny Higgins was also supported by a Population Research Infrastructure grant (P2C HD047873) from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). Bethany Everett is also supported by NICHD (R01HD091405), and Madelyne Greene and C. Emily Hendrick are both supported by a Health Disparities Research Scholars Training Program from NICHD (T32 HD049302). The content is solely the responsibility of the authors and does not necessarily represent the official views of the funding organizations. Finally, the authors thank (Lindsey Christenson) and (Jenna Powell) for their valuable research assistance, as well as our research participants for their time and contributions to the study.

Funding

This study was supported by the Society for Family Research Fund (SFPRF11-II3, SFPRF10-II3). At the time of this study, J. A. H. also received support from a Population Research Infrastructure grant (P2C HD047873) from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), B. G. E. also received support from NICHD (R01HD091405), and M. Z. G. and C. E. H. were supported by the National Institutes of Health under a Ruth L. Kirschstein National Research Service Award (T32HD049302) from NICHD.

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Table 1.

Participant characteristics.

Participant Characteristics	N = 33
Sexual Identity	
Queer	9
Queer + Another identity *	8
Bisexual	6
Lesbian/Gay	4
Other **	6
Race/Ethnicity	
White	26
Latina	2
† Other	5
Highest Education	
High School/GED	1
Some College	12
Bachelor's Degree or higher	20
Mean Age	23.8

* Many participants identified with queer and another identity, such as bisexual, femme, or lesbian.

** Other identities included fluid, demisexual, pansexual, and "not-straight"

†: "Other" racial/ethnic identities included participants who described themselves as Asian-American, Arab-American, and mixed race.