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Emerging Adult Women's Perceptions of Long-Acting Reversible Contraception (LARC): A Grounded Theory Investigation

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I am submitting herewith a thesis written by Elena Schuch entitled "Emerging Adult Women's Perceptions of Long-Acting Reversible Contraception (LARC): A Grounded Theory Investigation." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Psychology.

Patrick Grzanka, Major Professor

We have read this thesis and recommend its acceptance:

Kirsten Gonzalez, Jioni Lewis

Accepted for the Council:

Dixie L. Thompson

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

**Emerging Adult Women's Perceptions of Long-Acting
Reversible Contraception (LARC): A Grounded Theory
Investigation**

A Thesis Presented for the
Master of Arts
Degree
The University of Tennessee, Knoxville

Elena Schuch
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ABSTRACT

Long-acting reversible contraceptive devices (LARC) have been identified as the “first-line” option (ACOG, 2009) in preventing pregnancy, but little attention has been paid to how the intended users of these devices actually experience them. In response to Grzanka and Frantell’s (2017) call for increased attention to issues of reproductive justice within counseling psychology, the present study sought to understand emerging adult women’s experiences with LARC. The researchers conducted six focus groups with 30 undergraduate women, with each group audio-recorded and then transcribed for analysis. Data were analyzed using a modified grounded theory approach (e.g., Fassinger, 2005) and situational analysis (Clarke, 2005). A critical reproductive justice lens was applied to the data, through which a theory of conditional agency related to contraceptive choice emerged.

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CHAPTER ONE

LITERATURE REVIEW

While psychologists have begun to acknowledge the importance of identities such as social class, race, and gender identity and how they intertwine with systems of power and oppression, Grzanka and Frantell (2017) argue that at least one significant aspect remains unexplored: sexual and reproductive autonomy, specifically as it is conceptualized within a reproductive justice framework. Rather than emphasizing sexual and reproductive rights unilaterally and without consideration of how the intersection of various identities come into play, reproductive justice (RJ) seeks to illuminate the ways in which systems of power, inequity, and other pieces of identity impact women's sexual and reproductive autonomy in vastly different ways (Ross, 2017; Luna & Luker, 2013).

Where empirical research that takes a reproductive justice approach is limited, research foregrounding women's experiences with long-acting reversible contraception (LARC) is even scarcer. Though the devices were initially stigmatized due to widespread, high profile medical complications (e.g., infertility; Takeshita, 2010), the new generation of LARC has been heavily promoted as the primary means by which to prevent unintended pregnancy (e.g., Gubrium et al., 2016). Given LARC's growing ubiquity within public health spheres in conjunction with consideration of the reproductive oppression historically experienced by the targets of LARC promotion (Roberts, Kaplan, & Bassett, 2016), critical examination of how the intended users of LARC actually perceive and experience the devices is needed. While scholars of other disciplines (e.g., sociology) have begun such critical examination, herein lies a crucial

opportunity for counseling psychologists to make meaning of intended users' experience of and relationship to LARC, and, thereby, advocate for and empower these users from an RJ lens.

Accordingly, the proposed research sought to advance the currently limited RJ literature using a qualitative approach to specifically gain a better understanding of how emerging adult women perceive and experience LARC.

Reproductive Rights to Reproductive Justice

Reproduction has been identified as a key women's rights issue throughout the twentieth century in concordance with the deepening understanding of its significance as a social and political, as opposed to simply biological, issue (Almeling, 2015). However, predominant reproductive rights activism is grounded in a single-axis approach focused on relatively privileged, cisgender, White women, the root of such an approach being its assumption that gender is the main factor influencing sexual and reproductive health decisions (Grzanka, Brian, & Shim, 2016) with the focus centered on acquiring or preserving rights centered on cisgender women's bodies (Luna, 2010; Luna & Luker, 2013; Ross, 2017). Following the arrival of family planning resources and reproductive health clinics in the 60s and 70s, access to contraception primarily benefited middle-class White women at the same time as mainstream feminists framed reproductive rights in terms of the right to contraception as well as abortion (Stern, 2005).

As a legacy of this unilateral approach, current family planning programs and policies seek to encourage personal agency, specifically promoting what are seen as "agentic behaviors" such as pregnancy planning and prevention (Jones, Frohwirth, & Blades, 2016). However, while rhetoric around abortion and fertility is usually framed in terms of choice, this does not take into account how women experience reproduction differently along race and class lines; the choice

perspective does not explain all women's experiences (Zucker, 2014). Whereas reproductive rights activism has generally taken a gender first approach that presumes unilateral restriction upon sexual and reproductive agency, reproductive justice (RJ) activists seek to delineate the ways in which individuals' intersecting identities, both marginalized and privileged, impact and construct their experiences with sexual and reproductive health (SRH; Luna & Luker, 2013). Reproductive rights, then, can be defined as analogous to what Crenshaw (1991) called *identity politics* in contrast to reproductive justice as *structural intersectionality*, or the critical examination of how (in this case) women are situated within systems of power. Cole (2009) suggests examining the role of inequality by looking "upstream" (i.e., considering how social categories are embedded in systems of power and oppression) and, thereby, discovering the differences *and* similarities underlying mechanisms of behavior.

From this frame, the elimination of reproductive oppression must move beyond single-axis reproductive rights advocacy to intersectional analyses of how individuals experience reproductive issues multilaterally (i.e., systemically) and subjectively (Ginsburg & Rapp, 1991). As Luna (2016) notes, people might theoretically *understand* how various forms of oppression (e.g., gender and racial) occur simultaneously, but *in practice* fail to accommodate these complexities, resulting in the frequent privileging of one identity over another. Rather than highlighting individuals' multiple identities while stripping away how such identities are situated within systems of power—what Grzanka and Miles (2016) termed an "intersectionality-lite" approach—RJ advocates must frame their understanding of how women experience reproductive oppression asymmetrically.

Historically, reproduction has been stratified according to race and class, with certain types of reproduction privileged over others. Namely, White fertility has typically been encouraged while that of poor women and women of color has been controlled (Takeshita, 2010; Stern, 2005). While affluent White women were fighting for abortion rights, women of color and poor women simultaneously struggled against efforts to control their reproductive decisions given the widespread belief that they were “destructive overbreeders” (Stern, 2005, p. 113). According to Ross (2017), reproductive oppression goes beyond, but does not preclude, abortion rights advocacy; rather, it must also consider other oppressions such as misogyny, white supremacy, and neoliberalism. Consequently, RJ praxis necessarily goes beyond pro-choice rhetoric in using an intersectional human rights framework including not only the right *not* to have a child, but the right *to* have children, as well as parent them in supportive environments free from individual or state-level violence (Ross, 2017).

Different restrictive practices disproportionately affecting poor women and women of color have been extensively documented, including forced sterilization and abuse (Stern, 2005), reproductive coercion (Sufrin, Kolbi-Molinas, & Roth, 2015), and family cap policies intended to limit childbearing (Romero & Agenor, 2009). However, RJ expands the meaning of population control beyond explicit coercion to include any practices that limit reproductive agency for marginalized populations. For instance, women of color have reported greater odds of being advised to limit their childbearing compared to White women (Downing, LaVeist, & Bullock, 2007) and experiencing pressure from healthcare providers regarding their contraceptive use (Gomez & Wapman, 2017), not to mention believing that the government tries to limit reproduction of women of color by encouraging contraceptive use (Rocca & Harper,

2012). Becker and Tsui (2008) provide evidence substantiating such beliefs: upon conducting interviews with White, Black, and Latina women assessing the extent to which they expressed racial, ethnic, and language-based differences in their preferences regarding delivery of reproductive health services as well as how they perceived its quality, the authors found that Black women were more likely to be report having been pressured by a healthcare provider to use a contraceptive method compared to White women.

Though women of color have essentially *always* been targets of reproductive oppression from transatlantic chattel slavery through Clinton era-welfare “reform” (e.g., Bridges, 2011; Hancock, 2004), eugenic policies have historically employed a broader scope that includes anyone deemed “unfit” or a drain on taxpayer resources—including women of low SES (Stern, 2005). Beginning with Indiana in 1907, a total of 32 U.S. states would come to pass sterilization laws at some point in the 20th century. The language used to justify such legislature ranged from calling compulsory sterilization a “prophylactic measure” (Stern, 2005, p. 1130) in defense of public health to direct comparisons of eugenic policies to the eradication of deadly diseases such as malaria and smallpox. Further, limiting reproduction of the “hereditarily defective” (p. 1130) would ostensibly work to the benefit of the common good by weeding out undesirable genes. For example, compulsory sterilization in California was deployed as a public health strategy to limit reproduction of the “unfit” and “feebleminded” for the overall betterment of society—terms that were revealed to be (a) racially coded through sterilization practices disproportionately affecting women of color and (b) gendered by targeting women the state deemed incompetent and/or improper candidates to be mothers (Stern, 2005, p. 1130).

The indelible legacy of such policies is well represented by women's continued distrust of healthcare providers. Among 50 women who participated in focus groups, Higgins, Kramer, and Ryder (2016) found that not only did women of color disproportionately indicate *not* trusting their healthcare provider, women across racial groups expected providers to recommend LARC more often to women of color, poor women, and women perceived to be uneducated and/or unintelligent by providers. White women in the study cited historical injustices as linked to current LARC promotion, while participants of color were more likely to describe historical injustices as personally affecting them and their communities to the extent that they were warier of LARC recommendations as a result. These perspectives are well founded; specific state and federal policies seeking to limit poor women's sexual activity and childbearing as a means by which to reduce poverty were introduced in the 1990s (Romero & Agenor, 2009) with public health officials intending to reduce rates of unintended pregnancy (UP) as well as unintended births, both of which are disproportionately higher among women of color, poor women, and women with less educational attainment (Finer & Zolna, 2016; Mosher, Jones, & Abma, 2012). For example, the 1996 Personal Responsibility and Work Opportunity Reconciliation Act signed into law by President Bill Clinton incentivized out-of-wedlock childbearing to encourage marriage, specifically targeting communities with high rates of children born outside of marriage—i.e., poor women and women of color (Fine & McClelland, 2006).

Teen and unintended pregnancies are often framed as a costly public health problem that contributes to poverty (Peipert, Madden, Allsworth, & Secura, 2012) with UP often framed as a cause, as opposed to a symptom, of structural inequality (Gubrium et al., 2016; Higgins, 2014). From a traditional public health perspective, pregnancies should be both planned and intended,

with efforts targeted toward increasing the use of “highly effective long-acting methods” as a means by which to lower rates of UP (Finer & Zolna, 2016). The fundamental assumption of hegemonic public health scholarship holds that UP contributes to or causes poverty; the requisite solution to economic inequality, therefore, is to reduce UP as a direct means by which to eliminate poverty. This supposition holds UP as (a) objectively defined across all groups of women as well as (b) unidirectionally linked to poverty. In other words, in attempting to specify how reductions in rates of poverty occur, the outcomes are reductively privileged over comprehensive understanding of the reflexive process by which structural inequalities and poverty are co-constituted.

Others, however, conceptualize UP as an imposed rather than objective construct (Wise, Geronimus, & Smock, 2017), consequently suggesting that increasing access to contraception cannot be expected to significantly reduce rates of unintended pregnancy or poor outcomes among the socially marginalized. Though rates of UP tend to be higher among women of color, such pregnancies are not always defined as “unintended” by the women themselves (Sweeney & Raley, 2014). Because unintended births are not an objective categorization, increasing access to contraception cannot be expected to significantly reduce rates of unintended pregnancy or poor outcomes among the socially marginalized and, moreover, preventing so-called unintended pregnancies is less beneficial than promoting reproductive equity or justice. Rather, preventing so-called unintended pregnancies are likely less beneficial than promoting reproductive equity or justice and discussion of barriers to contraception should be situated within understandings of how structural racism and poverty drive health disparities (Roberts, Kaplan, & Bassett, 2016).

As Wise, Geronimus, and Smock (2017) write, “by constructing unintended pregnancy as a public health problem that stems from a lack of correct or skillful ‘planning’ or self-efficacy in contraceptive use, rather than as a distinction that is culturally and socioeconomically variable, policies and programs that aim to decrease its rate may be misguided and unnecessarily stigmatizing to already marginalized groups of women, rather than health promoting for mothers and children” (p. 12). From this perspective, the promotion of LARC use in an attempt to lower rates of UP, and thus lowering alleged cost burdens for taxpayers, prioritizes individual behaviors in keeping with neoliberal ideals of sexual agency (Bay-Cheng, 2015). Ironically, rather than alleviating economic burdens and reducing poverty as intended, such strategies have the potential to perpetuate inequality by failing to address systems-level issues.

Situating LARC Within Public Health

Given the frequent divide between hegemonic public health perspectives and those more attuned to a reproductive justice framework, LARC must be situated somewhere in between. Although LARC have existed for decades, methods such as the intrauterine device (IUD) were initially stigmatized—at least, for certain users. When the IUD was created in the 1960s, it was thought to make long-term pregnancy prevention easily achievable given that it was “impossible” (Clarke, 2000) by a third-party provider who only had to convince patients to accept the device (Takeshita, 2010); women of color, specifically, were targeted in order to “take control of their fertility” (p. 42) and encourage population control. The Dalkon Shield, an IUD created in the early 1970s, was largely promoted to emerging adult and nulliparous women but was taken off the market after causing infections, infertility, and several deaths. Because of the perceived connection between STIs and the risk of pelvic inflammatory disease (PID), the risks for which

increase with promiscuity, the legacy of this disaster was the creation of the “ideal” and “safe” IUD user: parous and monogamous.

Though IUD use declined in the 1980s as concerns arose over its safety, interest in IUD uptake as a means of preventing UP grew following a redesign in the 1990s (Branum & Jones, 2015). Recently, LARC have been identified as the most effective, “first-line” contraceptive option in preventing pregnancy (ACOG, 2009) with overall LARC use currently estimated at 14% among contracepting individuals (Kavanaugh & Jerman, 2018). Increasing LARC uptake and reducing unmet contraceptive needs are seen as effective strategies some believe will reduce (a) health disparities (Blumenthal, Voedisch, & Gemzell-Danielsson, 2011; Mosher, Moreau, & Lantos, 2016; Reeves, Zhao, Secura, & Peipert, 2016) and (b) costs, since UP is often framed in terms of economic burden (Trussell, et al. 2013; Morse et al., 2012; Birgisson, Zhao, Secura, Madden, & Peipert, 2015). From this perspective, UP and the consequences associated with it are deemed preventable, and populations most “at risk” of UP should be targeted—in other words, young and poor women, as well as women of color. Consistent with such public health initiatives, Dehlendorf et al. (2010) found that providers were more likely to recommend intrauterine contraception (IUC) to Black and Latina women than to White women—but only when they were of low SES. They were also less likely to recommend IUC to a low SES woman than to a high SES woman, but only when the woman was White; the authors postulate this difference as based in classist stereotypes framing lower SES women as more likely to contract STIs, from which IUC offer no protection.

Despite public health efforts to increase LARC uptake among certain populations, others may experience barriers to access. Because of historical risks to fertility, nulliparous women

were eliminated as potential users (Takeshita, 2010): “by redefining the appropriate user [post-Dalkon Shield], developers were able to argue that the technology was actually inherently safe and that it had just been inserted in the wrong women in the past” (p. 46). Notwithstanding current standards citing LARC as appropriate for use among the majority of women, providers’ misconceptions and failure to provide evidence-based information restrict many women’s access to the devices (Cheng & van Leuven, 2015). Although IUD use steadily increased between 2002 and 2013, primarily among parous women and those aged 25-34 (Branum & Jones, 2015), as did general LARC use among college women from 2008 to 2013 (Logan et al., 2018), the devices are considered to be under-utilized among this population despite their safety and effectiveness, in part because of providers’ misperceptions. Wu, Gundersen, and Pickle (2016) found that 40% of family planning educators and providers in their study used overly restrictive eligibility criteria regarding IUD use, restricting patients’ access to the devices; male providers in particular were less likely to be up-to-date regarding knowledge of contraception.

In a study assessing contraceptive counseling provision among emerging adult women, Gibbs et al. (2016) found that adolescents were just as likely as older women to receive LARC counseling, but nulliparous women were less likely to receive LARC counseling, and subsequently use a LARC, compared to parous women. Harper et al. (2013) surveyed 589 nurse practitioners (NPs, providers of frontline care in women’s health) regarding their clinical knowledge and provision of LARC methods, with results indicating that NPs often did not view adolescents and nulliparous women as IUD candidates due to the perception of relatively high risks relating to PID and infertility. Lower risk perceptions (typically lower among NPs with higher knowledge) were associated with higher provision of IUDs. However, when providers are

trained on LARC, their competency in incorporating discussion of the devices in contraceptive counseling and provision of the devices increases (Thompson et al., 2018).

Misperceptions regarding the safety of LARC also persist among patients, and such lack of knowledge about contemporary technologies has been framed as a barrier to access (Gomez, Fuentes, & Allina, 2014). Burns, Grindlay, and Dennis (2015) surveyed 520 women about their experiences with, awareness of, and interest in LARC and permanent contraceptive methods (i.e., female and male sterilization). The most common concerns with LARC influencing non-interest were regarding side effects and safety, which the authors cited as a legacy of older, riskier LARC devices.

Other barriers restrict women's access to the devices, including cost (Rocca et al., 2016) and lack of provider skills (Thompson et al., 2016). When Foster et al. (2015) surveyed 104 LARC experts regarding their views about the future of LARC use and promotion, including their assessment of barriers to greater LARC use, they found that cost of the devices was the most commonly cited barrier (63%), followed by women's knowledge of safety and acceptability of LARC and expectations about use (i.e., side effects and placement). Some researchers suggest that removal of these types of barriers would increase LARC use (Janiak et al., 2018) and, moreover, that is an ethical obligation to do so (Society for Adolescent Health and Medicine, 2017).

There is considerable support for a connection between the removal of structural barriers and increased LARC use. Secura et al. (2010) outline the Contraceptive CHOICE Project, which was developed in the St. Louis area to provide no-cost contraception to women and promote the use of LARC through the removal of financial barriers and increasing patient awareness of

LARC safety and efficacy. The authors found that 67% of women enrolled in the project who were not using contraception or willing to switch methods at the time of enrollment chose LARC and attributed the high LARC rates to patient education, cost removal, and offering and providing IUCs to all women regardless of age, parity, or STI history. Moreover, Secura et al. (2014) found that teens and women for whom financial, information, and access barriers to contraception were removed had lower rates of abortion, pregnancy, and birth compared to the national population of sexually experienced girls—which the authors associated with provision of LARC specifically. Further review of the CHOICE Project led Birgisson et al. (2015) to claim that “improved access to LARC methods can result in fewer unintended pregnancies and abortions and considerable cost savings to the health care system” (p. 349). Kavanaugh, Jerman, and Finer (2015) attributed an increase in LARC use between 2009 and 2012 to higher clinical emphasis on LARC as first-line options for pregnancy prevention for women of all ages, as well as policy and programmatic efforts to remove access barriers (e.g., by offering LARC for free).

However, other scholars have suggested that the results of women’s contraceptive decision-making are more complex than the removal of access barriers (Gomez, Hartofelis, Finlayson, & Clark, 2015). Even when knowledge and access are not an issue, factors such as spectrum of pregnancy desire (and correspondent receptiveness to LARC), the perception of LARC as too permanent (i.e., reducing agency), life stage and age influences (e.g., feeling more open to the idea of pregnancy as they got older), and relationship stage influences have been found to impact women’s interest in LARC (Higgins, 2017). Lessard et al. (2012) had 574 women at high risk of UP rate the importance of 18 contraceptive method features, finding that effectiveness, lack of side effects, and affordability to be most commonly rated; additionally,

they found that Black women were more likely than White women to care about features relating to control. Zeal, Higgins, and Newton (2018) found that perceived autonomy (e.g., control over pregnancy prevention) was an attractive feature of LARC, while lack of knowledge or understanding of the devices was a deterrent.

Another factor impacting contraceptive decision-making is how women experience contraceptive counseling, with higher satisfaction relating to contraceptive use (Dehlendorf, Krajewski, & Borrero, 2014). While the provision of contraceptive counseling has been identified as a basic component of reproductive care (Akers, Gold, Borrero, Santucci, & Schwarz, 2010), different approaches have yielded varying results. Dehlendorf, Kimport, Levy, and Steinauer (2014) have posited three contraceptive counseling approaches: foreclosed (i.e., providers gave information only when specifically asked), informed choice (i.e., providers gave and introduced information but left the choice up to the patient), and shared decision-making (i.e., collaboration between provider and patient). Whereas a shared decision-making approach was almost ubiquitously used among women 35 and older, women were more likely to be counseled with a foreclosed approach the younger they were. In a study examining 345 women's experience of shared decision-making, defined as healthcare providers' provision of medical knowledge in conjunction with patients' description of personal values and preferences, 96% of participants reported satisfaction with the process following shared decision-making compared to those who made their own contraceptive decision (88%) or who adhered to their provider's decision (63%; Dehlendorf, Grumbach, Schmittiel, & Steinauer, 2017). Taken together, these results suggest that younger women are more likely to receive directive counseling that women perceive to be problematic and as diminishing their reproductive autonomy (Dehlendorf, Levy,

Kelley, Grumbach, & Steinauer, 2013) and thus be less satisfied with their experience—which, in turn, reduces their likelihood of using contraception at all.

Equally as important as LARC access is to ensuring women’s reproductive autonomy is access to LARC removal (Strasser, Borkowski, Couillard, Allina, & Wood, 2017). Amico, Bennett, Karasz, and Gold (2017) conducted interviews with providers regarding their experiences with patients requesting early LARC removal, finding that physicians reported often trying to “sell” the IUD, even struggling to avoid pressuring their patients to use it. Moreover, despite discussing the importance of patient autonomy, providers often reported encouraging their patients to continue using the IUD unless they felt the patient had a “good reason” or had tried “hard enough” (p. 109).

At the same time as recognizing the need to remove access barriers, Gomez, Fuentes, and Allina (2014) call for prioritizing women’s needs and preferences ensuring access to LARC above efforts to promoting its use among “high-risk” populations, the latter of which could denote reproductive restriction as opposed to autonomy. They propose that the goal should be ensuring every woman has the opportunity to have a LARC if she wants one by removing barriers to access, rather than targeting LARC usage among specific populations. Some argue that even framing LARC as a first-line choice by definition removes choice from the equation and fails to consider individual needs and preferences by valuing certain types of reproduction over others (Gubrium et al., 2016).

While LARC clearly have several benefits, including near-perfect efficacy and user acceptability, several issues with LARC should be addressed in the context of promotion efforts (Higgins, 2014). From a reproductive justice framework, the goal of LARC promotion should

not be to reduce public expenditures (e.g., by reducing UP) or even simply to reduce UP. Rather, efforts to increase access to LARC should continue *and* women’s decisions regarding whether and when to have children as well as whether and when to use or not use LARC (including having LARC removed) should be respected. In a thematic analysis of interviews conducted with women seeking abortions by Brandi, Woodhams, White, and Mehta (2018), 42% of participants reported being pressured by providers to use contraception, and LARC in particular. Participants perceived providers as less coercive if they were presented with a range of contraceptive options, with both pros and cons delineated; conversely, participants who were presented with limited options expressed feeling less control over their ability to make an informed decision. Moreover, participants expressed their perception that, for providers, abortion symbolized their ineffective use of contraception that led to unintended pregnancy—highlighting the degree to which “agentic” behaviors are encouraged in lieu of providing structural support.

(Neoliberal) Agency and/in/as LARC Promotion

As a consequence of emphasizing the goal of unintended pregnancy prevention, LARC are now promoted in terms not only highlighting their contraceptive effectiveness but marketing them as the most empowering choice (Mann & Grzanka, 2018). If LARC fit within a narrative of agency and rational choice, women can see themselves as what Elliott (2014) termed the *responsible sexual agent*—an ideal drawing from the historical legacy of sex ed in the U.S. Fine (1988) argued that sex education illustrates several discourses: a discourse of sex as victimization wherein girls learn to deflect risk—of disease, of pregnancy, of being used by men; a discourse of morality that places values upon girls’ sexual decision-making, but only if they choose abstinence; and a discourse of (women’s) desire that is largely absent and, when present,

is tinged with the notion of consequences for risks taken. Legislation funding abstinence-only sex education discursively ties notions of personal responsibility to teen sexuality, suggesting that any consequences following the failure to be abstinent fall solely on the sexual actor (Elliott, 2010); meanwhile, comprehensive sex ed presumes that teens will take responsibility in avoiding sexual risks by using contraception (Fields, 2012). Either way, the burden of responsibility is to be shouldered by the individual.

Building upon neoliberal ideas of personal agency, Bay-Cheng (2015) proposed a model by which girls' (and emerging adult women's) sexuality is marked not only along the classic Virgin-Slut continuum, a double bind of acceptable sexual behavior, but through an intersecting Agency Line purportedly measuring individual agency and personal responsibility wherein girls are judged both for their alleged sexual activity as well as the extent to which they appear to have control over their sexual behavior. Though neoliberalism ostensibly celebrates personal agency, its "hegemonic imperative" (p. 280) demands free will to such an extent that the failure of its exertion invalidates one's existence. In other words, the idea of sexual agency is marketed in terms of choice and freedom while, in practice, leading to blame. Within this narrative, girls' abstinence or degrees of sexual activity are moderated by the extent to which they are perceived as exerting control or choice therein—with the additional layer of having to negotiate preexisting stereotypes that some girls are shielded from due to their class and race privilege.

Within Bay-Cheng's (2015) model, girls deserve the consequences of risky or careless sexual behavior (e.g., unintended pregnancy, sexually-transmitted infections) if it is perceived to be agentic. Indeed, victimhood is defined in terms of personal weakness and losing control as opposed to resulting from external perpetration or systemic forces of inequality. Garcia (2009)

argued that sex education poses risks to Latina youth through its heteronormative, gendered, and racialized lessons insomuch as they may have limited access to information and, moreover, be classified as at-risk of unintended pregnancy as a result of their emphasized racialized and gendered identities rather than taught to critically examine social inequalities that impact them.

What is still missing, then, is what Fine and McClelland (2006) call a discourse of *thick desire*, wherein teen girls have publicly funded opportunities to develop intellectually, emotionally, and otherwise; imagine themselves as sexual beings capable of pleasure and cautious of risk without bearing the brunt of the consequences; have access to information and healthcare resources; be protected from violence and abuse; and rely on a public safety net of resources. In terms of LARC, the narrative of personal agency proliferates, subsuming all possibilities of complexity in how women negotiate them.

Barcelos (2018) conceptualized discourses of youth sexuality and reproduction in community-based sexual health promotion efforts as gendered racial projects regulating Latina reproduction. By uncritically promoting LARC, the historical reproductive oppression experienced by women of color is erased and a neoliberal emphasis on individual behaviors over the recognition of structural inequalities is promoted. Gomez, Mann, and Torres (2018) found an overarching concern about IUDs restricting personal agency (citing invasiveness and inflexibility) among emerging adult Black and Latina women with unfavorable views of the devices. In contrast, women with favorable views of IUDs saw the devices as enhancing their reproductive freedom through their efficacy in pregnancy prevention and duration of use. These divergent perspectives highlight a tension between the currently predominant discourse

surrounding IUDs as symbols of reproductive freedom and agency and some women's negative evaluations—in other words, what Mann and Grzanka (2018) call “agency-without-choice.”

To answer Grzanka and Frantell's (2017) call for increased attention to sexual and reproductive health advocacy within counseling psychology, LARC as heretofore impossible devices must be understood in terms of the individuals who negotiate their use. Despite the ubiquitous relevance sexuality has for individuals across the lifespan, little attention has been paid to training counseling psychologists in sexuality-based competencies (Mollen, Burnes, Lee, & Abbott, 2018). Further, the topics most frequently included in existing sexuality training center on gender and sexual identity, relationships, and sexual trauma/abuse, while reproductive health and justice—including women's negotiation of LARC devices—remain wholly unexamined. If, as Mollen et al. (2018) indicate, SRH is pervasively disregarded among counseling psychologists, a substantial part of women's lives is not only being ignored but disenfranchised; indubitably it goes against the field's emphasis on individual empowerment and movement toward social change (e.g., Vera & Speight, 2003). In order for counseling psychologists to effectively advocate for and empower LARC users (or potential users) from an RJ lens they must understand how these devices might be promoted unfairly, restrictions upon their use placed heterogeneously, and, through future research, what insidious motivations underlie the multilateral policing of individuals' sexual and reproductive autonomy.

Before addressing the underlying systemic issues, however, counseling psychologists must first gain a phenomenological understanding of whether and why women choose to use these devices, the meaning they make of their decisions, and how their social locations might come into play. The present study is a crucial foundational step toward building that knowledge

and, accordingly, sought to understand (a) college women's experiences with/understanding of LARC, (b) the extent to which they experience LARC as enhancing or constraining their reproductive agency, and (c) how privilege and inequality impact their experiences with the devices.

CHAPTER TWO

METHODS

Overview

Participants ($n = 30$) were recruited through email, flyers, and snowball sampling on a large, predominantly White, Southeastern university campus to participate in one of six audio-recorded focus groups (each involving four to six women) facilitated by the graduate student researcher and co-facilitated by two undergraduate research assistants. The groups explored participants' knowledge about LARC and their experiences attempting to obtain and use these contraceptive methods, as well as how they arrived at their decision to use or not use a LARC. Additionally, participants discussed (a) where they have sought reproductive health care, (b) what happened when they did seek services, (c) what they were offered, and (d) how they felt about their interactions with health care providers. Focus groups were professionally transcribed and analyzed by the graduate student author and two undergraduate research assistants using a modified grounded theory approach (Corbin & Strauss, 2008; Fassinger, 2005) supplemented by situational analysis (Clarke, 2005), all of which was advised and audited by the faculty investigator.

Positionality

The graduate student author, who also acted as the focus group facilitator, is a White, queer, cisgender woman. The faculty investigator—a White, queer, cisgender, man—is a professor in Counseling Psychology with interdisciplinary training. Two undergraduate research assistants, both of whom are White, queer, and trans and involved in the Women, Gender, and

Sexualities program at the University of Tennessee, were involved in participant recruitment, data collection, and data analysis.

Participants

A total of 30 emerging adult women (ages 18-24, see Table 1) participated in one of six focus groups. The majority of the sample was White (80%) with considerable sexual diversity. Though participants reported their parents' education level and occupation(s), their own subjective socioeconomic status was not reported. However, participants' class was interpreted through the dialogue itself.

Data Collection

Study team members posted and distributed recruitment flyers in university buildings, recruited participants through tabling in the university library, and engaged participation through snowball sampling. Potential participants communicated with the graduate student researcher via email in order to determine availability for a group.

Data collection took place between November 2017 and April 2018. Focus groups containing 4-6 women took place in the principal investigator's university laboratory space, where refreshments were provided. Each group lasted between 50 and 90 minutes and was audio-recorded following the informed consent procedures. All of the focus groups were facilitated by the graduate student researcher and co-facilitated by two undergraduate research assistants. Participants completed a demographic questionnaire (see Appendix A) at the start of the focus group. A facilitation guide (see Appendix B) created for a similar study at the University of South Carolina was used for each focus group, wherein a semi-structured format for the discussion was followed. Topics covered included learning about birth control,

Table 1
Demographic Characteristics

Characteristic	Number	Percentage
Race/Ethnicity		
Black/African American	2	6.7
Latina/Hispanic	1	3.3
White	24	80
Asian/Pacific Islander	2	6.7
Mixed	1	3.3
Sexual Orientation		
Heterosexual	16	53.3
Lesbian	1	3.3
Bisexual	6	20
Pansexual	5	16.7
Queer	1	3.3
Questioning	1	3.3
Birth Control Method		
IUD	11	36.7
Implant	3	10
Birth Control Pills	8	26.7
NuvaRing	1	3.3
None	7	23.3

participants' contraceptive views and experiences, and birth control in the context of relationships.

At the conclusion of each group, participants were debriefed. Following the sixth focus group, the principal researchers determined that saturation had been reached. The audio recordings from each group were professionally transcribed using Rev.com, the funding for which having come from a departmental research grant awarded to the principal investigator and graduate student researcher. Transcriptions were checked and corrected by the graduate student researcher before beginning analysis.

Analysis

Data were analyzed using a modified grounded theory approach (GT; Corbin & Strauss, 2008; Fassinger, 2005) wherein data were grounded in the lived experiences of participants and concepts emerged inductively from analysis of the data. Further sampling of participants and reflexive modification of emergent theory continued until theoretical saturation had been reached. Situational analysis (Clarke, 2005), which is a method by which the positions of GT-generated data are visually mapped out to identify discursive elements that are otherwise obscured by transcripts and codes, was also used. Specifically, positional maps were used to visually represent how key concepts that emerged from the data related to one another; positional maps are essentially graphs in which qualitative data are transformed into a visual field along at least two axes. Here, situational analysis made visible how women negotiated LARC according to important theoretical concepts that emerged from the data. By physically mapping out participants' experiences on different continua, salient patterns as well as sites of silence across participants' experiences could be identified.

A reproductive justice lens was applied to data analysis in order to generate a theoretical basis upon which to better understand emerging adult women's perceptions, experiences with, and understanding of LARC. Team members analyzed data through two rounds of coding (open and axial), engaging in a reflexive process wherein data were compared to emerging concepts until theoretical saturation had been reached. In keeping with Moradi and Grzanka's (2017) guidelines for conducting psychological research that uses intersectionality responsibly, data analysis was approached with the intent to garner understanding of participants' relationships to LARC as framed at both the personal and systemic levels.

During a coding process lasting from May to July 2018, the research team began by engaging in a round of open coding using Atlas.ti, creating a list of 204 inductively generated codes to which all members contributed. Once all transcriptions had been openly coded, team members discussed and edited the open coding list, cutting out or collapsing superfluous codes as well as organizing codes into concept groups, before engaging in axial coding to identify interrelationships between categories. Team members met after coding each transcription (weekly on average) to talk about new and redundant codes, discuss process, analyze themes, and conceptualize theory, which was promoted through the practice of writing memos throughout the coding process. Following the second round of coding, team members determined which concepts were the most important in relation to theory development. The faculty investigator audited team members' analyses throughout the process and provided guidance for theoretical direction. Using situational analysis, data were mapped in accordance with major codes. Once the code list was finalized, one additional round of coding was conducted with the data's codes erased to confirm the coding schema.

Methodological integrity was maintained in accordance with recommended best practices for qualitative research in psychology (Levitt, Motulsky, Wertz, Morrow, & Ponterotto, 2017) through continued exploration until reaching saturation and the consistent contextualization of data within a grounded theoretical frame. The process of data analysis was reflexive inasmuch as all researchers involved in the work made explicit (through discussion between team members and individual memo-writing) their thoughts on emerging theoretical ideas. Having multiple coding teams and external auditing facilitated continuous feedback and identification of salient codes that constructed a meaningful conceptual model.

CHAPTER THREE

RESULTS AND DISCUSSION

Results

While our ¹ participants' knowledge of and experience with LARC varied extensively, their desire to use or avoid LARC was consistently framed within (a) their sexual identity and subsequent fear of pregnancy (or lack thereof); (b) their perception of risk as influenced by the quantity and quality of information they received about LARC; (c) their capacity to get contraception, which was impacted by both their social identities and broader structural barriers; and (d) the internalization of gendered messages regarding how they should contracepting. Ultimately, we saw these women's reproductive choices—and the meaning they made of those choices—as embedded within neoliberal ideas about women's sexuality that, consequently, functioned as agency-without-choice.

Negotiating Reproductive Anxiety and Risk

Reliability and effectiveness in preventing pregnancy were consistently named by our participants to be the most important aspects of any given birth control. Perhaps most important about our participants' desire to use or not use LARC methods was the extent to which they wanted to avoid getting pregnant—or what we conceptualized as their level of *reproductive anxiety*. Higher reproductive anxiety seemed to motivate these emerging adult women to use

¹ Though I was the lead researcher for this study, I use the first-person plural as a feminist move acknowledging that this research involved a collaborative effort between myself, my mentor, and two undergraduate research assistants.

LARC for their perceived effectiveness above and beyond other contraceptive methods, even when there were perceived risks (e.g., pain, side effects, infertility), as exemplified by Sarah (22, White, heterosexual):

I'd say I chose Mirena because I'm, like, honestly, the most irresponsible person you ever met. Not irresponsible, but I just lose things and forget things all the time. So, I wanted something I didn't have to worry about. I knew I couldn't be responsible enough to take the pill, and I really enjoyed that you didn't get your period. I also have super bad anxiety. So, I knew all the time, I want a birth control that I'm not going to worry, like, "Am I pregnant? Am I pregnant? Am I pregnant?" Because still, even now, sometimes I'll be like, "I wonder if I'm pregnant," and I've had the Mirena for, like, five years.

While presenting herself as a firm proponent of her LARC, Sarah later described how having the IUD inserted was the worst pain of her life. She immediately followed up with the assertion that "it was fine. The 30 seconds of pain compared to five years of me not having a child is definitely worth it." Similarly, Lydia (19, White, bisexual) equated the pain of her IUD insertion to what she imagined having a child must be like, saying, "Oh, gosh. I'm so glad I have this. If I just take a second... I do not want to get pregnant and feel that pain." For those women who did use LARC—all of whom experienced adverse side effects to some degree—the projected gain of using LARC was assessed to be worth any literal or proverbial pain. Above and beyond the possible consequences, these women were motivated to use LARC to avoid getting pregnant.

When participants' fear of getting pregnant was less salient, they tended to avoid the devices; in our groups, this manifested in participants who had sex with men infrequently or

whose sexual partners were mostly women (see Figure 1). When asked whether she would ever consider getting LARC, Hannah (19, Black, heterosexual) explained:

Yes. Eventually. I'm not in any relationship, I'm not seeing anyone, I'm not talking to anyone, so I don't see any—the only reason why I'm on the pill, I guess, is for my periods. But I don't see it necessary in getting that and being in that pain for a little while. Just because I'm not in a committed relationship or with a partner.

Though in a committed long-distance relationship with a man, Connie (23, Asian, bisexual) said she does not use birth control since she “never” sees her partner. Abby (20, White, pansexual) said that birth control was “not applicable” to her since her sexual partners tend to be women, which Courtney (24, White, lesbian) echoed: “Admittedly I have never used birth control, ever. I only sleep with women. So, for me, I feel like I haven't needed it.” Katlin (21, White, bisexual), who is in a committed relationship with a woman, similarly rejected the need for LARC, saying they are “probably not for me. The occasional times I sleep with guys it's just easier to not, I don't need something that serious.”

In contrast, women who had sex with men regularly were much more likely to either have a LARC or consider using one in the future. None of our participants was interested in getting pregnant anytime soon and found LARC appealing if they saw the devices as long-term, safe, and effective in preventing pregnancy. For instance, Emily (21, White, bisexual) described how, when she was looking for birth control, she chose the implant “because on the brochure that I was given, it said that the implant was right next to being sterilized.” Kate (21, White, heterosexual) and Liz (23, Asian/Pacific Islander, heterosexual), both of whom were casually dating and sleeping with men, strongly endorsed their IUDs for the “peace of mind” they

Relationship Status & Birth Control Choice				
IUD	+++	++	+++++	+
Implant	+		+	+
Pills & NuvaRing	+	+++	++++◇	
None	++	+◇	+	+◇
	Not dating	Casually dating	Serious relationship	Living w/ partner
	Note: ◇ = current partner is female			

Figure 1. This positional map demonstrates the contraceptive methods (Y-axis items) used by our participants and their relationship status (X-axis items). None of our participants who were currently in a relationship with a woman, regardless of sexual orientation, used LARC. For those who did use LARC, the majority were in a serious relationship with a man.

provided. For Kate, getting LARC eased her worry of “what if the condom broke, what if there was a hole.”

Participants’ levels of commitment in their relationships with men seemed to increase their perceived risk of pregnancy and, thus, their interest in LARC. Faith (22, White, bisexual) discussed how her level of reproductive anxiety, and consequent decision to get a LARC, transformed as her relationship with her boyfriend became more serious:

It's definitely easier to have sex with it...I was still having sex on the pill but there was still that worry in the back of my mind of, “oh if I forget a pill, if it fails, what could happen?” There's, like, a 99% chance that I won't get pregnant with the IUD. So, every time I've been to the doctor since I've gotten it they're like, “are you on any birth control?” I'm like, “I have an IUD” and they're like, “oh, so no chance of you being pregnant.” I'm just like, “yeah, that's great to hear.” It's super comforting to hear that. It's easier.

Cheyenne (21, White, heterosexual) discussed why she had been considering LARC as a result of her increasingly serious relationship with her partner:

I've been interested in it because quite frankly I'm not really interested in kids, but they don't offer permanent solutions to people our age, so that's, like, the next best thing... At first [not having a period] was weird because I thought it was unnatural... And then I kinda developed the irrational fear of like, “oh my god, I'm always pregnant, I'm so scared.”

Gina (21, White, pansexual), who dated a woman for several years before starting a relationship with a man, expressed feeling so “paranoid” about getting pregnant that she asked her partner,

“Should we find other forms? How many different kinds of birth control can I be on at once? Will it help?” Similarly, Maddie (20, White, heterosexual) discussed how her contraceptive decision-making changed as a result of her evolving relationship:

I didn't get around to getting an IUD until I was in a committed relationship...Because I wasn't sexually active, on a regular base sexually active, so I was using condoms with my boyfriend...I look at the percent of the risk rates and stuff, and also as someone who's listened to the Health Center's talk about properly opening a condom, I'm like, “Did you open that correctly, did you feel the little air packet?” My boyfriend's like, “Enough.” I just talked to him about, “I think I want to get a more permanent solution.”

While high reproductive anxiety seemed to motivate emerging adult women to use LARC for the devices' perceived effectiveness above and beyond other contraceptive methods, many women felt apprehensive about these devices depending on what they had heard about them (see Figure 2). Participants commonly expressed hearing or reading “horror stories” about sterilization or other statistically rare side effects, such as infections of the arm (Julie) or uterus that resulted in hospitalization (Ruth), IUDs “getting caught” (Gina and Dana), infertility (Maddie), or a baby born holding an IUD (Carolee, Kate, and Sarah). Notably, these so-called horror stories—and the fear stemming from them—seemed principally about IUDs. And, the more participants seemed to see LARC as risky, the less they considered using them. For example, Abby said that:

[LARC] seem kind of scary because they list this giant list of side effects—that's intimidating...it would go inside of you and they would talk about surgery, and it lasting

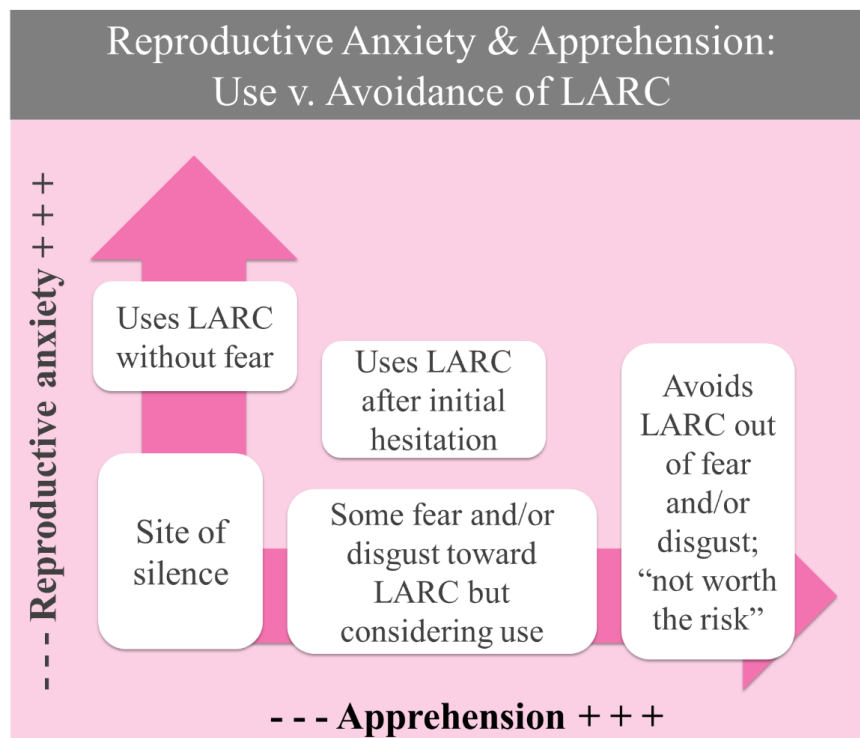


Figure 2. This positional map illustrates the relationship between participants' level of reproductive anxiety (Y-axis), the degree to which they felt apprehension about using LARC (X-axis), and their consequent decision to use, consider using, or avoid LARC. As women's level of reproductive anxiety increased, their desire to use or consider using LARC increased. However, as women's level of apprehension increased, so did their reluctance to use or consider using LARC. High reproductive anxiety combined with low apprehension resulted in women's use of LARC without fear or disgust. High apprehension combined with low to medium reproductive anxiety resulted in women's avoidance of LARC out of fear and/or disgust. Negotiation of risk occurred when participants had both some level of reproductive anxiety *and* apprehension, resulting in hesitation before using or considering using LARC. None of our participants had both low reproductive anxiety and low apprehension, resulting in a site of silence.

3 years and, like, it's non-reversible or causing side effects. I was like, “why would someone go through all this trouble for it?” So that seemed scary to me.

Despite participants’ ostensible awareness of how horror stories were sensationalized (e.g., “But those are horror stories, you don’t hear those from actual people,” Julie, 22, White, queer), the fear such stories inspired was enough to give these women significant pause. As Dana (20, White, heterosexual) said, “I mean, it's like one in a million, but I just feel like I would be that one in a million, so I’d rather not take the risk.” Savannah (22, White, bisexual) who explored LARC as a “longer-term fix,” seemed to view the IUD as higher risk and, consequently, turned to the implant to manage her reproductive anxiety:

I was looking at IUDs but also just thinking of having something like—like it can cause problems in a more serious manner than just in my arm causing problems with a certain implant. So, I guess that's why I was leaning towards NEXPLANON versus an IUD. I kind of looked at it, but thinking about it I was just like, “I don't want anything up there”... IUDs still to me are almost not worth the risk of having cervical issues and all of that good junk.

When participants talked about IUD risks, sterilization seemed to inspire the most fear but was simultaneously rationalized as implausible; pain, however, was a more tangible possibility. Like Savannah, Emily indicated choosing the implant since she associated the IUD with “serious issues...like extreme cramping” that she was unwilling to risk. For her, the possibility of pain was not worth the hassle. Similarly, Connie and Dana both expressed feeling hesitant about LARC after hearing about how “painful” insertion of the devices can be.

While apprehension toward all types of LARC was based in fear, women who avoided the implant tended to also express disgust towards it. Sarah, who was a firm proponent of the IUD, described feeling scared and even “nauseous” by the idea of the implant, while Kate said it made her feel “squeamish.” For Carolee (21, White, heterosexual) the implant “just didn't really make sense to me. You don't have sex with your arm; it's down there.” Faith, an IUD user, expressed fear for both types of LARC but said she chose not to use the implant since being able to “feel something” in her arm was worse than any other risks. This sentiment was echoed by several participants, especially when the three women who did have an implant (spread across two groups) all invited their fellow participants to touch their implant; women universally reacted to such invitations with disgust. In explanation, Liz told a story about a friend who had experienced the implant insertion negatively, saying “her arm was all bruised, and, like, swollen and bloody, and I was just like... it didn't go through well, and I just told myself I was never going to do that. But I also get freaked out with things going into where I can feel and see.” In contrast, Maddie indicated that being able to see and feel her implant made it appealing, saying, “I like it because my biggest fear with the IUD was it moving and me not knowing, and this, like, I'll look down and be like, ‘Oh, it's still there. It's still good.’”

Although for some women using LARC was equivalent to *having* control because of the reduced risk of pregnancy and freedom from the burden of reproductive anxiety, for others having a LARC seemed to mean *losing* control. In other words, some participants seemed to cede agency to a foreign object about which they had little knowledge or understanding. Lauren (21, Black, questioning) expressed her avoidance of LARC in terms of maintaining control over her own body:

I just considered pills alone, just because the idea for me, like having something inside of me that I can't control, scares me. I'm one of those people, if I hear, like, one horror story, I'm done. Plus, the way my body is, if I don't have the ability to change it as easily, like with pills you can change it pretty quickly, but I feel like with an IUD it's a little bit harder, or with any kind of LARC it's a little harder.

Though eventually she chose to use an IUD, Zoe (19, White, pansexual) also talked about being interested in using birth control pills as opposed to LARC when she first started having sex since “it was something I could stop and start if I wanted to.” Indeed, the pill was often framed as a “temporary” form of birth control that could be easily stopped—an attractive quality for participants reluctant to use LARC. When asked why she thought the pill was predominantly used, Natalie (23, White, heterosexual) responded:

Just because it's what doctors push first. It's something that, should you choose to be on a form of birth control, it's what you're probably going to be prescribed and put on first. So, for a lot of people, or at least for me, it was something where it's like, at least I'm familiar with this way of taking it. Whereas everything else is a procedure, so there's just a little bit more involved there. Maybe it's just me, but I think that there's still a lot of misconceptions out there, too, about the implant and the IUD. And then also just a lot of fears about it and everything like that since it's a little bit more invasive in that way.

Kaitlin explained people's apprehension toward LARC as “a lack of knowledge that makes people automatically nervous or negative towards it just because they don't know.” In comparison to other contraceptive methods, Emily said LARC “seem more foreign. And even if they have been around for a long time, you haven't heard about it, and you haven't heard your

friends or family growing up talking about it, so you might think it's less trustworthy, or something might be weird about it.”

Positionality and Access: Getting Contraception

Though reproductive anxiety was prevalent among participants who had sex with men, apprehension about LARC was rooted in unreliable information quality, gatekeeping by healthcare providers, and structural barriers (e.g., cost) seemed to prevent women’s pursuit of—and/or restrict access to—the devices. Among our participants, satisfaction with the sexual education they received was rare—and *never* expressed by women who grew up in Tennessee. Most of the women’s experience with sexual education was abstinence-only; when birth control was mentioned at all, condoms or the pill were the only options discussed. Savannah described her sexual education as “just enough to say we talked about it, you know about it. You know about the primary option, the cheapest option.” Julie said she “didn't get any sex ed from the school system” and “thought that the pill was literally the only option ever in the world for years, which is concerning.” Several women, such as Courtney, even expressed that their participation in the focus group itself was a learning experience, since their contraceptive knowledge before then had been “limited.”

Instead, our participants relied on getting information about birth control once they got to college, usually as a result of becoming sexually active. Mel (21, White, pansexual) mentioned not knowing anything about contraception “until I thought that I needed it.” Similarly, Ellen (21, White, heterosexual) said that her first time learning anything about birth control was when she went to see a gynecologist. Lauren, among others, said that “better” and “clear” information access would make choosing a birth control method easier. As Mel put it,

I feel like just more openness from doctors and then better sex education because...we didn't start sex ed until sixth grade, and even then you had to have parents sign this huge permission slip...And even then when you did go, it was this whole, “just don't have sex or this bad shit will happen to you,” like, “this is going to happen and that's going to happen. You're going to be miserable.”...It was just shunning it and not really going over anything. And then, of course, going to the doctor or trying to talk to your parents it was kind of along the same lines. You were given some information, but a lot was withheld with this idea of either age or personal preference.

Our participants seemed to feel trapped in a double-bind wherein they lacked contraceptive information but were explicitly discouraged or shamed if they sought it. Without clear, unbiased, and accurate facts about contraception, these women struggled to make informed decisions. Faith, for example, recalled the difficulty choosing birth control without having received comprehensive sexual education:

Yeah, when I first started looking at the IUD online all I heard was horror stories and negatives about it. I was like, “oh my God, is this a terrible decision?” Then I had to remind myself that a lot of people will talk about their negative experiences but not as many people will talk about their positives. I had to remind myself that whatever I read online is definitely going to be, like, biased information from people who just want to complain about something that didn't work for them.

For Faith, negotiating her reproductive anxiety along with managing potential risks was difficult when faced with conflictual information from unreliable sources. In the words of Ruth (22, White, heterosexual), “I wouldn't say [information] was inaccurate, just incomplete. Pieces of the

picture I didn't have, I didn't make a fully informed decision because I didn't know all my options, kind of thing.”

Before participating in the focus group, Krissy (18, White, heterosexual) said that her contraceptive knowledge was “focused on condoms and birth control pills,” which she attributed to these methods being “the two easiest ones to reverse.” This conceptualization of LARC as more difficult to stop compared to other birth control methods was held not only by participants themselves but many of their physicians, restricting their access to LARC regardless of providers’ explicit intentions. Moreover, participants were frequently advised against getting LARC, pushed toward certain methods (usually birth control pills), or failed to receive information about all the contraceptive options available. Mel recounted being discouraged from getting LARC by her gynecologist:

For my doctor, I'm pretty sure it was the whole basis of, like, “oh, you're young, you don't know if you want to make this serious of a decision or not, or you don't know where you want to be this many years down the road.” So, it wasn't really given that option of, “I'm 100% sure I don't want kids until this age. I want to be safe until that age.” It's like, “oh, you might change your mind,” because of how old I was....When I finally brought up different methods later on, it was the whole, like, “that's a big long ordeal, what if you want to change your mind, or you're like, ‘I want to have kids,’ you're going to have to come get it taken out, you're going to have to deal with that. What if it fails and causes an issue and you can't have kids? The pill is the safest way to go,” and I wasn't really given any option. That was when I decided I'm not going to come to you anymore because you

clearly just want to keep me on this one set track, not let me tell you what I think would be okay to do or what I feel is right for my body.

Implicit in the message Mel received from her doctor was that getting LARC was not worth the risk to her fertility, suggesting that (a) LARC is dangerous and (b) Mel would definitely want children someday. Among others, Carolee received similarly gendered messages from her doctor, saying that he tried to “discourage” her from getting an IUD because she did not yet have any children.

Beyond holding women accountable to traditional gender norms, some participants experienced providers as restricting their very autonomy not only through the (usually limited) contraceptive options providers offered, but through the meaning scripted into providers’ interactions with patients. Participants spoke about birth control pills as prescribed to them by default—what Amanda (21, White/Hispanic, heterosexual) called “a good starter birth control”—that functionally constrained women’s ability to make a contraceptive choice. For instance, Gina’s gynecologist “was like, ‘Here, I’m going to put you on the pill,’ and that was the only conversation we ever had about it. There was (sic) no options or anything.” Cheyenne initially went on the pill since it would be easy to stop if she wanted to, but when she talked to her doctor about switching to LARC:

They were just like, “you have a great experience with it, why would you want to do that. An IUD is like a procedure” and all this kind of stuff. They kind of advertise it as this long arduous process when it isn’t necessarily that way.

Whether or not a medical rationale for this discouragement existed, by failing to provide Cheyenne with any information, her contraceptive autonomy was restricted. Kylie (21, White, heterosexual) described a similar experience trying to attain contraception:

I feel like the pill's pushed hardest, at least from both of the gynecologists I went to. One of them was open to letting me use NuvaRing but I mean, they really pushed the pill the first time. Then when I wanted to get off the first one, it was just another pill. It's like their go-to and I feel the conversation doesn't draw from, "Those are more long-term methods. You're only 19, 20 years old, you don't need those." It's almost like they don't trust that since you're not in a committed relationship, maybe, or maybe you're not 30 or 40, you don't get to have long-term choices.

In this case, Kylie's ability to make an informed decision was limited by the contraception her doctor offered. Her provider seemed to imply that more long-term options would become available when she was "older," thought when this might be was never explicitly defined. Natalie also seemed baffled by the arbitrary age limitations providers imposed:

I understand why they would want to do that to somebody really young. But then once I got into my 20s and everything like that, but they're still discouraging it. It's like I have gotten older but, you know... again, I didn't really want it, but it was definitely like, "what are all my options?" and they would tell me them. It was like, "but you really only want a few of these options. You don't want that stuff over there," which is interesting.

For other women, access to LARC was restricted by structural barriers. Emily's gynecologist, for instance, was not trained in or certified for LARC insertion, so a "special person" had to insert it for her, while Krissy said that she would have to travel to "the next town over" to even be able to

see a gynecologist. In discussing LARC accessibility, Hannah framed cost as even more of a deterrent to women than fear of pain:

I feel like pain's, like, pain—like, you'll be fine, but I feel like there are so many drugs you can take to handle that. But I think it's the cost that kinda, like, pushes people away. Especially I feel like, my friends that are a bit reckless, they can't afford to get the pill or something. Or have the accessibility to get some form of birth control besides maybe Plan B or something. So, I feel like that's why they aren't going for the IUD. Maybe they're not on their parents' insurance or they don't have the funds to pay for those types of things.

The issue of affordability resonated for many of our participants, who explained being limited in their contraceptive options based on insurance coverage—if they had insurance at all. Julie talked about being unable to access LARC despite wanting one because her insurance would not cover the cost of the insertion procedure. Conversely, Savannah explained that she switched from the pill (\$60 per month) to her implant (free) because the LARC was covered by her plan. Liz, who had no health insurance, said she only acquired her IUD through the A Step Ahead program that provided it for free, without which she “wouldn't have been able to have access to it. That would have been obviously like a brick wall.” When insurance is not a barrier, providers may still function as obstacles to contraceptive access—particularly contraceptives that are as socially contentious as LARC.

Even when women personally experienced no difficulties accessing birth control, they consistently named affordability as a potential obstacle to seeking LARC. Sarah, who got her

IUD through her parents' insurance, expanded upon the issue of cost in terms of limiting autonomy:

I guess now I know how blessed I am to be able to take birth control and have access to that, but I think about how expensive Mirena is and how expensive birth control can be. I know you can get the pill and stuff but, again, for reduced or free through the government. But then again, that's not the best for everyone's body. So, just in a larger scale, I wish it was more accessible because I think, what if I wanted to have sex and I couldn't afford birth control; so now I'm either choosing between having a kid in high school or I'm choosing to not be able to do something that I should have the right and the access to do.

When cost was not an issue, some participants had difficulty accessing LARC in a timely manner. Several women mentioned having to book appointments months in advance, sometimes finding out too late that the contraceptive method they were trying to access was not available with that provider. Though insisting that getting her LARC was worth it since it lasts “seven years,” Carolee denounced the steps she had to take to access it:

It would have been easier to just, if I had, before signing up to go to the Student Health Center, they said, “Hey, we don't put in PARAGARDS.” Just seeing one person and having it set all out, like, “this is what you need to do: this, this, this. Done.” Instead of having to go to all these different people and keep up with appointments while still having sex with a condom and having to take Plan B.

Maddie encapsulated her perspective regarding the various issues with accessing LARC:

I just wish there was more information, and it wasn't like... I think that more girls would be on birth control if it didn't mean taking, like, five hours of your life total to research, go get more information, book an appointment, wait three months, go get the IUD put in, or get the NEXPLANON put in. Especially as college students, I know my friends and I, we have, like, two hours of our day that are not scheduled, so if it was more convenient, which it should be with how, I don't know, for whenever you hear about other medications that are necessary for your life, it's like you can go get that. But for a girl to get on birth control there is so much stigma, and it's so time-consuming.

For these women, getting contraception meant negotiating not only their own perceptions of the risks, but attempting to navigate making a decision within the constraints of the quality of information provided, the contraceptive methods offered to them, the costs of those methods, and, as outlined in the next section, pressure to perform their gender well.

Responsible Sexual Agency: A Neoliberal Take on Contracepting

In their meaning-making of LARC and the personal experiences influencing their contraceptive decisions, our participants reflected a neoliberal form of gender accountability (West & Zimmerman, 1987) emphasizing personal empowerment, agency, and sexual discipline. However, these women's reproductive autonomy was functionally limited by their internalization of discourses of personal responsibility and the gendered messages providers and other women communicated regarding their contraceptive decisions, resulting in a sort of agency-without-choice.

Gender accountability and/in/as responsibility.

Although participants consistently talked about not being given comprehensive information about LARC (i.e., from providers, from school-based sexual education), as well as recognizing other structural barriers limiting their access to the devices, they seemed to feel shame for their lack of education and pressure from other women to appear prepared, informed, and knowledgeable. When this was not possible, participants appeared to censor themselves or adopt the views of others around them. As the focus group facilitator, I sometimes felt as if participants acted like they were in a class: instead of openly admitting their lack of knowledge or talking about their experiences without justifying their contraceptive decisions, they seemed to feel pressure to be “correct” and “responsible,” whether or not they used LARC. Our participants who *did* use LARC seemed to defend their decision by framing it as *responsible sexual behavior*—even when side effects (e.g., extreme pain, irregular periods) negatively impacted their lives. Emily, who had her implant for three years, talked about having a negative experience with her LARC, but when Savannah described getting an implant in part because of Emily’s recommendation, Emily’s tone switched:

I feel like I might have recommended it. Because, I mean, recommended it with the condition that I experience extremely irregular bleeding, because that's me personally and that's not going to happen for sure because everyone's bodies are different and it'll react differently. So, I think I, I feel like I recommended it to you because I hadn't had any other side effects or anything like that. I'm not against it. Not something like, if I had an IUD and I had horrible cramps, I don't think I would recommend that, because this is, it's

just an inconvenience having really irregular bleeding. It's not like it's really stopping me from living my life or making me feel horrible or anything. It's just annoying.

Though recognizing that her experience was individual, Emily seemed on the defensive regarding her contraceptive choice. Other participants, such as Amanda, continued to advocate for their LARC in ways that felt, to me, like an alarming negotiation of cognitive dissonance:

I tell everyone I have an IUD, I'm like, "you need one." Like I tell all my friends. One of my friends is getting an IUD because I talked it up so much. I was like, "it's literally the best." It was so painful for me to get it, like I almost fainted, I had to sit down because the room was spinning. She was like, "sometimes people faint." And I have a pretty high pain tolerance, but it hurt me so bad, but I tell all my friends that they need it.

Zoe likewise described experiencing "horrible" pain for six weeks after her IUD insertion, but insisted that she tells all her friends "yeah it's great, I don't have to take any pills or anything, we don't use condoms, it's fantastic." Kate explained how "shitty" it was to have irregular and heavy periods for nine months after getting her IUD yet tolerated her side effects because she "never [has] to worry about being pregnant at the end of the month." For these women, feeling that they were engaging in sexual activity *responsibly* made using LARC worth any hassle.

Even when ostensibly acting as responsible sexual agents, participants seemed to feel conflicted about how they were "doing" their gender (West & Zimmerman, 1987). Lydia seemed to anticipate judgment from others as she defended her choice to have an IUD:

If other people have asked me if I'm on birth control, I told them, but I don't disclose it more. It's not that I'm necessarily ashamed of it, but I just don't really want to have anyone be like, "Oh, you don't need to do that," especially with other family members. I

know I do have family more that would be opposed to that. I know what I want to do, so I don't want to hear any other things about it.

Lydia seemed wary of judgment regarding both her sexual activity and potentially irresponsible contraceptive use, since others might perceive that using LARC could result in fertility problems. Many other participants were discouraged from using LARC by other women in gendered terms.

As Sarah described:

I've definitely been discouraged a lot from it. A lot of people...It's kind of crappy of people to assume anyway, because they'll be like, "Oh. You're never going to have a kid." And what if I didn't even want to have a kid? What if that was not something I wanted for myself? ...The most thing (sic) that I hear, is, "you're never going to have a kid" or "you're going to have problems having a kid."

The message, echoed from providers, was that (a) LARC are dangerous and (b) all women will want children someday. Similarly, Amanda was warned away from LARC for the risks they ostensibly posed to her fertility:

Yeah, people I've talked to, some people have said, you know, "I'm not going to put a foreign object in my body and near my cervix." Like, "that's going to ruin my chances of pregnancy in the future. You don't know what you're getting into," like, blah, blah, blah. I think the people that I have talked to about it who have a negative opinion about it are very anti and feel like it's going to ruin their future of having children, kind of thing, and jeopardize that rather than it being just a form of birth control for right now.

Here, the women who explicitly told Amanda *they* would not make her same choice implied that she was doing gender irresponsibly in comparison to them.

Gendered judgments were also reenacted within the groups themselves. For Maddie, choosing to manage her reproductive anxiety was tainted by the implication that she did her gender incorrectly:

The health insurance then called my parents for some reason to approve it or whatever, or say that it had been approved. My mom called me and was, like, freaking out, was like, “I want you on birth control, but this is supposed to cause infertility, or whatever,” and this long thing. She was like, “What if you can't have kids ever? You're going to miss out on that part of your life.” For me, yeah that'd stink, but also I could adopt, like, that's not a big deal for me. I know that's horrific to say, but, like, I'd rather have that peace of mind now, and biological children is not the only avenue for me. I don't view that as being a lesser option, to adopt. I was like, “Okay, mom, I hear you, but—my life.”

Maddie’s labeling of her choice as “horrific” demonstrated the extent to which she was holding herself accountable to her gender, even as she framed getting LARC as an autonomous decision. Participants were explicitly supportive of one another’s choices and respectful of each participant’s contraceptive autonomy; when discussing women abstractly, however, participants often engaged in discourses of responsibility wherein they simultaneously recognized how social norms place the responsibility of preventing pregnancy upon women *and* demonstrating how they have internalized the necessity of taking on such responsibility. Participants, such as Mel, often named how unfair it felt to have the burden of responsibility placed solely upon them:

I feel like it's always been, the girls receive more negative connotation of, like, it was her fault because she wasn't doing her birth control correctly, whereas, clearly the guy had some role in there now being a baby or being a pregnancy that they needed to take care

of. I feel like there's all of that where, if something does happen, the girl's always given more of the blame.

In another group, participants discussed how pregnancy prevention is gendered:

Gina: It feels like the responsibility falls to the women.

Liz: Yeah, like they put all the pressure on us as women to be proactive about birth control methods, and, like, understand and be educated on that. And guys, they're just like, "okay, boys, make sure you bring a condom when you go out on a Friday night." Like sorry, that's not good enough. Don't be a dumbass, in my opinion.

Even as they expressed frustration with this gendered dichotomy, however, participants discursively held women accountable to what they felt was responsible. When discussing her perceptions of what forms of birth control other women use, Hannah said:

My friends are reckless. They don't like birth control because all the side effects that happen. Like the weight gain and stuff like that. So, they choose to use other methods that I'm not a fan of. But that's just their choice. That's their decision, they'll use condoms or the pull-out method, whatever. But that's their decision. But, I mean, I feel like I have other friends as well who are educated on sex positivity and use condoms the majority of the time or are on a form of birth control. But, I mean, to each their own. I feel like, personally, I'm just like, I'm on it. And use condoms, just because I don't want to have a baby or have an STD.

Though claiming to respect her friends' choices, Hannah's language suggested otherwise.

Similarly, Zoe described:

I think a lot of college students still just use condoms as their only form of birth control. I expected, because I was asking one of my friends if she wanted to come with me to this, and she's been in a relationship for a year and a half or so, and I expected her to either be on the pill or have an IUD or something, and she was like, “no, we just use condoms.” I was like, “dang, that's crazy to me.”

Savannah seemed to simultaneously respect women’s autonomy and judge them for what she deemed irresponsible sexual behavior:

My only thing would be if you're having heterosexual sex at the risk of pregnancy, then obviously don't just use the pull-out method. Use a condom or some type. And don't rely on Plan B because that shit's expensive... Other than—it just goes back to it's not really your decision of what they... or which method they do use because, again, it's their body.

Women across groups felt that the men they were having sex with should be more informed about contraception so as to distribute the burden of responsibility as far as pregnancy prevention, *and* continuously categorized responsible sexual behaviors in gendered, heteronormative terms. Beyond talking about their personal experiences having sex with men, the language our participants used to talk abstractly about women’s contraceptive choices often implied that (a) women who contracept are having sex with men, and (b) the presumed sexual pairing of one man plus one woman also includes the division of sexual practices along gendered lines. Helen, for example, described thinking “it's really weird how just not prepared [men] are with condoms. That's, like, the only thing you have to be responsible for with a dude”—which Carolee immediately supported by claiming that men “have one job.” In this case, both Helen and Carolee categorized condoms’ purpose as preventing STIs, the man’s “job,” while their own

contraceptive use was for the purpose of preventing pregnancy. Lauren, in her claim that men should learn how to use condoms, separated sexual practices by gender by suggesting that “before [men] even worry about what we've got going on, just worry about yourself.” Regarding men, Zoe said that “if they're a person who has sex regularly then they should also be prepared all the time, unless you're in a relationship and you know that your partner has an IUD or an implant or whatever.” The idea of being “prepared” was ubiquitous across groups and seemed to be defined by participants as men having condoms and women having birth control; to be “unprepared,” then, was to fail to properly contracept and akin to acting irresponsibly. Faith described having sex with a man who did not use a condom and her subsequent motivation to use contraception:

Afterwards I freaked out and was like, “oh my god, what did I just do?” And I went and bought Plan B the next day and I was like, “okay, this can't happen again, I need to be on some sort of birth control.” Because if he's going to be irresponsible, I need to be responsible.

Clarissa (20, Latina, heterosexual) who was casually dating and not on any birth control, said:

I don't know, because I feel like [men] should be involved, but also I think it's on us to kind of, I guess, like, protect ourselves. If we really don't want to get pregnant, then that's on us, but they do play a big role in it just because, I mean, they're also contributing. Okay, so if we were to get pregnant then they're a big contributing factor to it, obviously, so they should be involved in a way, but I think for the most part it's on us to, like, I guess, decide on the form of birth control if we're going to do that.

By framing pregnancy prevention and contraceptive use in terms of responsibility, these women—perhaps unintentionally—reinforced the gendered norms within which they are trapped.

When empowerment goes wrong: agency-without-choice.

The choice to use or not use LARC, then, was ostensibly defined by autonomy but, for these women, actually represented adherence to normative notions of responsible sexual behavior (Bay-Cheng, 2015, discussed below). Along with negotiating reproductive anxiety and structural barriers, the gendered messages women received impacted (a) whether they would seek out LARC and (b) their ability to access them. Rather than acting autonomously, our participants seemed to exercise a sort of *agency-without-choice* (Mann & Grzanka, 2018) whereby contraceptive decisions were differentially constrained depending on how each woman was situated. The extent to which our participants *felt* these restrictions, however, varied; constraints that felt tangible (e.g., cost) seemed more easily recognized than the more abstract ones (e.g., internalized sexism)—in other words, constraints that functioned as limitations versus those that were masked as freedoms. For example, these women universally expressed that they felt freer to make contraceptive choices once they got to college, and, therefore, able to seek out LARC. Maddie explained her perception that LARC were becoming more prevalent among undergraduates:

I think it's more about, the more hectic your life gets, and the further you get from your parents' control, the more that's like, when you're more of, like, a free-thinking human being. Because it's like, I kind of equate it to, when you're younger you get your ears pierced, and then you're rebellious if you get your belly button pierced, but that still can

be removed. Then as you get older you see people getting tattoos and stuff. I just think with age comes more permanent... It's not permanent, but longer-lasting things.

In response, Liz agreed that “you gain more autonomy” once leaving home. Sarah, while explaining what would make choosing birth control easier, said:

I guess, at first, when I first got my birth control, I was just like, “I just want something that is going to get me the furthest away from being pregnant. That's all I care about.”

But, now, as I've gotten older and gotten more into health and my own personal health, I wish I would have known which birth control was right for my body and what was the best for my health rather than what was the best for... and like, Mirena's worked fine.

Luckily, I've had a great experience with it, but I think knowing more about what would be best for me.

This “my body, my choice” mentality, to use Savannah’s words—which was nearly ubiquitous among our participants—seemed to function on the surface as autonomy and as a rationalization for making contraceptive decisions without being fully informed (by no fault of their own).

Along with not having comprehensive information, these women were constrained by the options their doctors presented to them. As Kylie described:

Yeah, I think doctors being more willing to let you as the patient have choices, like that’s the whole point, that you're supposed to have choices. But my doctor now is really good about listening more than the first one and I also think that's because she's a woman, not a man. But just being able to feel comfortable to even ask questions because, like, how do I know I want something? It's like, first off, you're only giving me information you want to give me, but maybe I feel uncomfortable about something and I want to know. If they're

more willing to let you ask the questions you want to ask, then maybe I would feel better about asking for different types of birth control... I think just at this age, this is what you're put on, you start on the pill and then progressively maybe you get more options.

Though Natalie spent most of the group speaking positively about her experiences with birth control, after hearing others' stories she was more openly critical:

I know the last time I went to the OB/GYN down here and everything like that, it was like I felt so rushed and everything. It was like, "you'd like birth control? It's probably a good option for you, this is the one that we recommend, you should be on this one," and also this stuff. I was like, "...okay." It was just really like, "can I have some options?"

While Kylie and Natalie, among others, described being warned away from LARC, others, like Savannah, Julie, and Ellen (all White), were encouraged to use it. Lauren, a Black woman, described being blatantly pushed to use LARC:

Every time that I would go to Planned Parenthood they'd be like, "so about that IUD" and I'd be like, "no I don't want that," and they'd be like, "but are you sure?" and I'm like, "yes," every single time. Every single time. Even when I go in the little chat room thing and ask about a random question, they'd be like, "so an IUD" and I'd be like, "no," every single time, "no." I haven't had that experience up at Fort Sanders yet but that's a little annoying, it's like, "I know at least what I'm doing for my body, please stop trying to tell me what to do."

Lauren's experience of providers pushing her to use LARC was so salient that, at the end of the group, she even said, "You didn't dissuade me, I'm still team pill, just so you know." The implication that I as the facilitator (a White woman) was trying to persuade her—and, thereby,

constraining her reproductive autonomy—was heartbreaking. Amanda’s description of how her mother and sister conspired to trick her into getting an IUD was equally uncomfortable to hear:

Yeah, [my mom] was completely all about it. She and my sister lied to me and said that it did not hurt and I was like, “all right, this is great.” Then I remember sobbing my eyes out, calling her and being like, “what the hell? Why did you lie to me? Why would you do that?” She was like, “well, I didn't think you would get it if we told you that.” That's how bad she wanted me to get it. I don't know why, probably because she knows that I'm really forgetful and I have a scatterbrain and don't take pills... so I was deceived, but it was worth it, I guess.

Throughout the group Amanda expressed being adamantly in favor of her LARC for how it reduced her anxiety about getting pregnant and, thus, allowed her the freedom to have sex with men worry-free, but the price for such freedom seemed her very agency.

Regardless of how these women felt about using LARC devices, they commonly saw LARC as being increasingly prevalent among millennials, expressing the possibility of advertisements’ influence. As Cheyenne posited, “the media has a lot to do with it, too, because from when I started the pill versus now I've seen a lot more articles about like, ‘have you tried the IUD? Have you tried the implant?’” Amanda, in reference to Lauren’s earlier disclosure about being pushed toward using an IUD, described seeing advertisements for LARC at her gynecologist’s office:

Yeah, I think more and more people are getting it. I also feel like, since more and more people are getting it, it's being pushed. Like maybe that's why they wanted you to get it, is because, whenever I go to my gynecologist's office, it's everywhere plastered on the

walls, the IUD diagrams and all this stuff. I don't know why, like they want people to keep up this trend going of the IUD.... everyone is starting to get it now and transitioning from the pill or the implant to the IUD that is, like, this magical thing where you don't have to take a pill and it's in there for five years and you're good for three to five years and you don't have to gain weight and you don't have acne and all that stuff.

Similarly, Kate's first exposure to LARC was through advertisement pamphlets at her gynecologist's office in high school, which she found "scary." According to Kate, commercial advertisements for birth control have changed since the first time she saw an ad for Yaz, a type of birth control pill, in middle school. She along with Maddie discussed their perception of how advertisements' targeted demographic has changed:

Kate: Now I'm seeing more commercials for the LARCs. Like on my Hulu, there are two kinds of birth control commercials. There's the one with the, it's in your arm, I like that one, but then there's the other one that's, like, for IUD, and it's the most annoying commercial I've ever seen. I'm like, "Can this be over yet?" But I don't see commercials, many commercials for, like, hormonal or oral contraceptives anymore. I see them more for, like, long-lasting ones. Part of me, not to bring this up again and again, but part of me wonders if it's, like, because it's, like, I know I see on social media girls talking about getting long-acting birth control because of the recent election, and people—maybe there's a bigger sense of fear that you won't have as much control over your reproductive system in the future. I don't know if that's actually what's happening or if I'm just seeing it through my lens.

Maddie: I also think the commercials have changed. Now they're targeting a younger generation, whereas the one I saw whenever I was little, it was, like, a woman who had already had two kids and just was in a marriage, and just didn't want to have any more kids. Now it's like, "you're a young independent woman, and you don't want a kid right now." They show women going to work, and being like, "I'm strong, I'm independent. I'm in this airport, and don't want to remember it." You know?

Kate: Yeah. Like they're catering to millennials?

Maddie: Yeah, like they're catering more to unmarried women.

For these women, contemporary LARC advertisements seemed to impose an image of the empowered, agentic millennial as one who chooses LARC. Within this frame, the choice *not* to use LARC seemed to equate to losing control over their reproductive health.

Through the messages reflected in such advertisements, our participants were further forced to negotiate (often conflicting) messages about what their contraceptive choices would mean for not only their identity as women, but as responsible sexual agents. Given how central the themes of empowerment/agency and normativity/discipline were in these focus groups, it felt important to read our participants' experiences against the existing empirical and theoretical literature on LARC, reproductive justice, and neoliberalism.

Discussion

We sought to understand what these women know and think about LARC, how (un)acceptable they find it, which factors influence their decision to use or avoid LARC, and what their experiences have been trying to access the devices. In contrast to the traditional public health perspective focusing on LARC usage and efficacy rates (e.g., Secura et al., 2010), this

study contributed to growing literature foregrounding women's *lived experiences* with LARC (e.g., Gomez, Mann, & Torres, 2018) that has the potential to shape contemporary sexual and reproductive healthcare policy. Rather than framing women as obstacles who must be convinced to use LARC in order solve the problem of poverty (e.g., Finer & Zolna, 2016), exploring how these women *feel* about LARC was an act of reproductive justice-making in and of itself à la Ross's (2017) discussion of the RJ tradition of storytelling. Though many unanswered questions arose that will be addressed below, our work exposed a complex of set of factors these women negotiated in their understanding of LARC, including reproductive anxiety, structural and gendered barriers to access, and fear based in misinformation. Moreover, their negotiation of these salient factors reflected their internalization of discourses of neoliberal agency that demonstrate how LARC are promoted.

For those women who did experience reproductive anxiety, at the root of their negotiation of risk and their consequent desire to use or not use LARC seemed to lie the internalization of "hegemonic neoliberal norms" (Bay-Cheng, 2015, p. 286) that emphasize individual autonomy and agency while ignoring systemic context. By classifying themselves as autonomous agents, these women justified their contraceptive choices to one another (and to themselves) as indications of *personal responsibility*—even as they simultaneously connected to each other in the focus groups over the ways they had felt restricted. Moreover, based on their own definitions, our participants categorized and judged the contraceptive decisions other women made on a continuum of heteronormative, gendered responsibility. In the context of these focus groups, we found that these women's meaning-making practices around LARC devices generally reinforced and perpetuated, rather than destabilized, gendered social dynamics that constrain reproductive

freedom. We situate these findings within the broader literature on sexual responsibility, neoliberalism, and reproductive justice, with an emphasis on how these women's experiences complement and extend existing accounts of the complexity of contraceptive access, use, and promotion.

Recall that Ross (2017) names neoliberalism, along with misogyny and white supremacy, as yet another form of reproductive oppression that must be dismantled through reproductive justice advocacy. Though originating in economic theory, neoliberal ideologies are now so culturally pervasive that virtually no aspect of social life has been left untouched by neoliberalism (Bay-Cheng, 2015; Grzanka et al., 2016). By diverting attention from structural forces (i.e., of power and oppression), neoliberal ideologies and rhetoric emphasize individual actions. Further, by dismantling the social welfare state (i.e., the public sphere) and promoting market-based (i.e., private) solutions to all social problems, global neoliberalism has produced new forms of sexual citizenship that demand subjects self-regulate and self-monitor according to hegemonic norms—what Foucault called “governmentality” (Grzanka et al., 2016). Produced within such ideologies is the idealization of what Bay-Cheng (2015) calls “unfettered free will” (p. 280) that, in terms of sexual and reproductive health, purportedly celebrates agency as divorced from the moral judgment against which girls' and women's sexuality has historically been measured. Functionally, however, the fetishization of personal agency merely replaces gendered sexual moralism as the new hegemonic imperative by which we judge women's actions. Women's sexual and reproductive decisions then become judged by the extent to which they are perceived as indicative of agency, control, and discipline.

Perhaps the most evocative example of neoliberal judgment in our groups was Hannah's description of her friends as "reckless" for failing to use contraception while being promiscuous, reflecting an insidious internalization of hegemonic neoliberal logic that reads as a sexual script of irresponsibility. Bay-Cheng (2015) notes that, in navigating the "matrix" (p. 287) of intersecting neoliberal and gendered moralist norms, women must push others below the "Agency Line" in order to maintain themselves above it. By labeling her friends as "reckless," Hannah seemed to be evaluating their actions against her own (ostensibly) more disciplined ones and, perhaps unintentionally, judging them in the process.

Whether she was aware of it or not, her (heteronormative) reasoning here seemed to be as follows: (1) Hannah's friends, who are women, are having sex with men and could become pregnant; (2) to become pregnant, presumably unintentionally, would be irresponsible; (3) women should use contraception to avoid getting pregnant; and (4) failing to contracept is irresponsible. Further, although the racial identities of her friends were never mentioned, Hannah, who was Black, seemed to have potentially internalized respectability politics, as well as stereotypes of Black women's hypersexuality (Lewis, Mendenhall, Harwood, & Browne-Huntt, 2016). By failing to demonstrate either a nuanced understanding of her friends' motivations, the possible barriers restricting their contraceptive decision-making (e.g., cost, lack of education), or critical awareness of racialized and/or gendered messages she may have internalized, Hannah confined her friends within a neoliberal double-bind wherein the sexual actions she judged to be negative were defined as "manifestations of personal deficits" (Bay-Cheng, 2015, p. 288) for which they must take responsibility. Their failure to be responsible went not only against neoliberal ideals of agentic behavior, but against their very gender.

As they engaged in neoliberal discourses of responsibility, our participants rarely discussed how their experiences were contextualized through and situated within broader systems of oppression. Though gender was at the forefront of the groups' discussions, at least in personal terms, race was a striking "site of silence" (Clarke, 2005) whether or not women of color were present in a group. While sites of silence may initially appear to be devoid of meaning for what they fail to articulate, critical examination of what at first appears to be absent can be productive. For example, I realized upon critical reflection that the focus groups' manifestation as predominantly White spaces were inherently racialized. Most of the people in our focus groups were White—including me and both research assistants. Therefore, it is worth considering whether the women of color who *were* present actually felt comfortable or safe in the space to express themselves. At least partially because of the participants' identities, discourse in the group centered on how White women experienced threats to their reproductive autonomy from a gendered (and sometimes classed) lens. Explicit discussion of any impact their own whiteness might have had, however, was missing. This is consistent with longstanding account of whiteness and privilege, whereby White people talk *around* their whiteness even when race is central to the situation at hand (Feagin, 2012). This site of silence (Clarke, 2005) can be read as a manifestation of our participants' racial privilege, which allowed them to focus on other targeted identities (e.g., gender) without having to consider race. I can only wonder to what extent our participants of color censored themselves in response, and to what extent my presence as not only an "authority" figure but White altered their comfortability of expression.

While acting as the (White woman) focus group facilitator, the only moment that felt explicitly racialized to me was when Lauren, a Black woman, insisted that her opinion regarding IUDs had not changed despite her participation in the focus group. The implication was that providers' repeated attempts to control her reproductive autonomy—and, perhaps, her knowledge of past and current reproductive injustices perpetrated against women like her—was so salient that I seemed to represent yet another authority figure trying to strip her of her autonomy. Though I read this interaction, and providers' attempts to control Lauren's decisions, as racialized, none of her fellow participants seemed to make this connection. Part of this may have been discomfort with talking about race explicitly, but it also seemed indicative of these women's lack of awareness of the history of reproductive oppression. Lauren's mistrust of providers is not unique (Higgins, Kramer, & Ryder, 2016), and, if this has been her experience when seeking contraception, how many other women of color are being similarly impacted? Beyond the emotional weight such mistrust places upon women who experience it, if women do not trust providers, their very willingness to seek out sexual and reproductive healthcare could be erased. In probing the interracial differences and similarities (Cole, 2009) in our sample, we were compelled to consider how the same behaviors—such as mistrusting providers based on technically inaccurate information about current LARC devices—may have different forms and meanings across racial identities. For example, when White women trade in misconceptions about LARC, they may inadvertently constrain their reproductive choices. Meanwhile, when women of color share negative experiences and histories of reproductive oppression that discourage LARC use, they may be resisting reproductive coercion and promoting freedom/choice. Our constructivist grounded theory approach helped to expose these

dynamics, and to identify the ways in which race and racism informed the lived experiences of women even when they do not name or mark race explicitly in their own self-reflections.

Class was likewise an axis on which these women negotiated LARC promotion and use. Three of the women—Savannah and Julie, both White, and Liz, Asian-American/Pacific Islander—who discussed being explicitly encouraged by providers to use LARC were of lower SES relative to other participants. In stark contrast, most of the women expressed feeling pushed toward other contraceptive methods and/or described having to advocate for their choice to use LARC before being permitted by a provider to use them. We know from the extant literature that providers are less likely to offer LARC counseling if they perceive the devices to be risky to women’s fertility (e.g., Harper et al., 2013)—but why was this perspective not shared with all the women?

Two possible answers arise: the first, that some providers were better trained in LARC provision and, therefore, more comfortable offering the devices (Harper et al., 2013; Thompson et al., 2018) since providers’ failure to give women evidence-based information on LARC could be based in their own misconceptions regarding the devices (Cheng & van Leuven, 2015; Wu, Gundersen, & Pickle, 2016). A second possibility is that something about most of these women’s individual identities (White, relatively higher SES) made any risk LARC posed to their fertility, whether plausible or not, unacceptable to their providers; recall that White fertility has historically been encouraged while that of poor women and women of color has been controlled (Takeshita, 2010; Stern, 2005). Though the motivation behind providers’ decision whether to offer LARC cannot be determined by the present study, it is important to consider the impact of their actions on these women. Namely, our participants’ experiences suggest poor women and

women of color remain the targets of efforts to limit their reproduction and, thus, their very autonomy.

If women of color and poor women continue to be disproportionately targeted for contraceptive use—as demonstrated extensively in other studies (e.g., Gomez & Wapman, 2017) and echoed through our participants’ experiences—the discourse of personal agency is rendered null and void. According to Bay-Cheng (2015), neoliberal discourse allows for either individual agency or systemic vulnerability—but not both. By “choosing” to be agentic, a woman is also forced to internalize the blame and/or consequences for her actions; to relinquish agency in favor of recognizing how she is situated within systems of power, conversely, would be akin to labeling herself a victim. Our participants, then, paid the price for their agency-without-choice (Mann & Grzanka, 2018) by internalizing personal responsibility.

Limitations and Future Directions

By looking “upstream” (Cole, 2009), our predominantly White and relatively privileged sample helped illuminate how undergraduate women at a southeastern university experience, think about, and make meaning of LARC. While their experiences might not generalize *statistically* (Luker, 2008), our analyses do provide insight into how the processes underlying undergraduate women’s relationships to LARC matter *analytically*—indeed, our goal from the beginning. Rather than measuring and verifying differences across categories, our work sought to discover what could be happening for these women who already exist within their unique social locations. Since there is so little understanding of how women actually relate to LARC, we cannot begin to know how to operationalize the processes by which these devices are negotiated without having first explored users’ phenomenological experiences. In other words, these

women's experiences with LARC matter because they offer insight into the processes through which LARC promotion and access materialize in women's lives.

The commonalities found through these women's experiences stood out as markers of the social inequalities underlying how different women experience reproductive oppression, while those experiences that were asymmetrical served to highlight how these women experienced oppression above and beyond the single axis of gender. To an extent, all of our participants experienced reproductive oppression in similar ways; unique to our White participants, however, was the privileging (and ensuing restriction) of their reproductive capacity by providers who, through their policing, conveyed to these women that they could not be trusted to make the right decisions for their own bodies. While our participants recognized and critiqued these dynamics to a degree, their awareness was limited to how such assaults to their freedom impacted them on a personal rather than systemic level. In other words, their criticisms served to perpetuate neoliberal rhetorics of individual agency and empowerment while largely decontextualizing their experiences from the systems of power in which they were situated. While future survey research might generate more representative data on perceptions of and practices of LARC use, our work unpacks some of the meaning-making practices that women engage in while navigating the complex landscape of contemporary sexual and reproductive health care and politics.

We employed a team-based, modified grounded theory approach in the interest of generating theory "grounded" in our participants' lived experiences. However, as Fassinger (2005) noted, one of the limitations of the academic research enterprise is that researchers typically have existing knowledge and expertise in their content area before the study design and data collection process commences. In other words, we are not typically naïve to our data, and

the present study is no exception. Nonetheless, we resisted situating our data in the published academic literature until after coding was completed, and while we found consistency between our findings and extant theory (i.e., agency-without-choice), new concepts emerged (e.g., reproductive anxiety) that are both inductively generated and extend existing research in this arena. Even as we sought to represent our participants in ways that reflect our feminist research ethics and political commitments, we did not engage in member-checking or other forms of participant validation. We also relied on the artificially constructed nature of the focus group setting to generate our retrospective self-reported data. While helpful for the purposes of understanding meaning-making practices, such data do not illuminate what women actually *do* with LARC. Future research should use other direct observation methods to identify the real-time behaviors and affect that women (and providers) enact in clinical encounters and everyday life as they attempt to access or resist LARC.

Though counseling psychologists are increasingly attending to sexual and reproductive health issues, contemporary academic discourse on sexuality—and RJ in particular—remains thin (Grzanka & Frantell, 2017; Mollen et al., 2018). The present work, though an important step forward, points toward the need for more nuanced, intersectional inquiry into the complexity of diverse women’s experiences. Further, we must expand beyond our understanding of how the privileged majority experience reproductive oppression to be more inclusive of the experiences of more marginalized women, particularly along racial and class lines, and individuals of diverse gender identities. Additionally, the proposed theoretical framework of LARC use/avoidance as a function of reproductive anxiety and risk negotiation provides a foundation upon which to conduct quantitative research exploring the key relationships influencing women’s experiences

with and perceptions of LARC. Of particular interest might be measurements of reproductive anxiety, apprehension, and the consequent use/avoidance of LARC. Given the present study's emphasis on agency, one potential approach could explore how individuals' neoliberal beliefs (e.g., Bay-Cheng, 2015) and locus of control relate to other relevant RJ constructs such as critical consciousness, respectability politics, slut-shaming, and abortion stigma. Another possible direction could be to explore providers' attitudes toward and experiences with contraceptive counseling, LARC provision, and how they contextualize sexual and reproductive health care within systems of power.

Clinical and Advocacy Implications

Although several questions that cannot be answered by the present study remain, our analyses do make evident the influence of neoliberal ideologies on women's conceptualization of their own and others' sexuality. If our goal as counseling psychologists and social justice advocates truly is individual empowerment as well as systems-level change, we must become more cognizant of how clients' discourses of agency and control might mask an insidious internalization of personal responsibility and, therein, the potential for self-blame. While counseling psychologists typically speak of sexuality in terms of identity and orientation, until we include sexual and reproductive health in our ostensibly holistic framework, a significant part of our clients' lives will go unaddressed (Mollen et al., 2018). This work, we hope, begins to amplify what has for too long been a site of silence: *sex* itself.

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APPENDICES

Appendix A

**Life with LARC Study
Demographic Survey**

Thank you for agreeing to participate in this research about young women's views of and experiences with long-acting reversible contraceptive (LARC) methods. Before we begin the interview, please fill out this survey. If anything is confusing, please let me know!

Demographic Background

- 1) How old are you? _____
- 2) What is your gender?
 - a. Female
 - b. Male
 - c. Other: Please specify _____
- 3) Which do you feel describes your racial/ethnic background? (Choose one)
 - a. Black/African American
 - b. Latino/Hispanic
 - c. White
 - d. American Indian/Alaskan
 - e. Asian
 - f. Pacific Islander
 - g. Mixed (specify) _____
 - h. Other (specify) _____
 - i. Don't Know
 - j. Refuse to Answer
- 4) What country were you born in?
 - a. USA
 - b. Other country: specify _____
- 5) Where did you grow up? _____
- 6) What is your current religion? (Choose one)
 - a. Catholic
 - b. Christian
 - c. Jewish
 - d. Muslim
 - e. Buddhist
 - f. None
 - g. Other religion. Specify "other" religion _____
- 7) What country was your father born in? (Choose one)
 - a. USA
 - b. Other country: specify _____
 - c. I Don't know

- 8) Which do you feel best describes your father's racial/ethnic background? (Choose one)
- Black/African American
 - Latino/Hispanic
 - White
 - American Indian/Alaskan Native
 - Asian
 - Pacific Islander
 - Mixed: specify _____
 - Other: specify _____
 - Don't know
 - Decline to answer
- 9) What country was your mother born in? (Choose one)
- USA
 - Other country: specify _____
 - Don't know
- 10) Which do you feel best describes your mother's racial/ethnic background? (Choose one)
- Black/African American
 - Latino/Hispanic
 - White
 - American Indian/Alaskan Native
 - Asian
 - Pacific Islander
 - Mixed (specify) _____
 - Other
 - Don't know
 - Decline to answer
- 11) What year of college are you in? (Choose one)
- First year/freshman
 - Second year/sophomore
 - Third year/junior
 - Fourth year/senior
 - Fifth year/super senior
 - Other; please specify _____
- 12) Do you have any children?
- Yes
 - No
- 13) If you have children, what is/are the age(s) of your child(ren)? _____
- 14) Which of the following best describes your current relationship/dating status?
- In a relationship that is serious, committed or long-term but not living together
 - Casually seeing or dating one or more people
 - Not currently in a romantic relationship or dating anyone in particular

- d. A member of an unmarried couple living together
 - e. Married
 - f. Divorced
 - g. Widowed
 - h. Separated
- 15) If you are currently dating or in a relationship with someone, what is their gender?
- a. Female
 - b. Male
 - c. Other: Please specify _____
 - d. Not currently in a relationship
 - e. Decline to answer
- 16) Which do you feel best describes your sexual orientation/identity?
- a. Heterosexual/Straight/Attracted to the opposite gender
 - b. Gay/Lesbian/Attracted to the same gender
 - c. Bisexual/Attracted to people of both genders
 - d. Pansexual/Attracted to people of any gender
 - e. Asexual/Not attracted to people of any gender
 - f. Other: Please specify _____
 - g. Decline to answer
- 17) What is the highest grade or year of school completed by your mother? (Choose one)
- a. Never went to school
 - b. 8th grade or less
 - c. Some high school, but did not graduate
 - d. Received high school diploma (or got a GED)
 - e. Some college or junior college, but did not graduate from a four-year college
 - f. College graduate (from a four-year college or university)
 - g. Some Graduate school but did not complete
 - h. Graduate Degree (Masters level)
 - i. Graduate Degree (PhD/Doctoral level)
 - j. Don't Know
- 18) What is the highest grade or year of school completed by your father? (Choose one)
- a. Never went to school
 - b. 8th grade or less
 - c. Some high school, but did not graduate
 - d. Received high school diploma (or got a GED)
 - e. Some college or junior college, but did not graduate from a four-year college
 - f. College graduate (from a four-year college or university)
 - g. Some Graduate school but did not complete
 - h. Graduate Degree (Masters level)
 - i. Graduate Degree (PhD/Doctoral level)
 - j. Don't Know
- 19) What was your mother's occupation when you were in high school? (Choose one)
- a. Working full-time: Please specify occupation _____

- b. Working part-time: Please specify occupation _____
 - c. Temporarily laid off
 - d. Unemployed
 - e. Student
 - f. Taking care of home or family
 - g. Other: Please specify _____
 - h. Don't know
 - i. Decline to answer
- 20) What was your father's occupation when you were in high school? (Choose one)
- a. Working full-time: Please specify occupation _____
 - b. Working part-time: Please specify occupation _____
 - c. Temporarily laid off
 - d. Unemployed
 - e. Student
 - f. Taking care of home or family
 - g. Other: Please specify _____
 - h. Don't know
 - i. Decline to answer
- 21) What kind of health insurance do you have?
- a. I do not have health insurance
 - b. Medicaid
 - c. Marketplace insurance
 - d. Private health insurance from my job or the job of my husband, partner, or parents
 - e. Private insurance purchased directly from an insurance company
 - f. Tricare or military benefit
 - g. Indian Health Services or tribal insurance
 - h. Some other kind of health insurance: Please specify _____
- 22) Are you or your partner **currently using** any of these types of birth control? (Circle all that apply)
- a. Tubes tied or blocked (female sterilization, Essure)
 - b. Vasectomy (male sterilization)
 - c. Birth control pills
 - d. Condoms
 - e. The Shot (Depo-Provera)
 - f. Contraceptive implant (a rod in your arm like Nexplanon)
 - g. Contraceptive patch
 - h. Vaginal ring (NuvaRing)
 - i. IUD with hormones (Mirena, Skyla, Liletta)
 - j. Copper IUD – no hormones (ParaGard)
 - k. Natural family planning (rhythm method)
 - l. Withdrawal (pulling out)
 - m. Not having sex (abstinence)

- n. Decline to answer
 o. I don't know
 p. Other: Please specify _____
- 23) Have you or your partner used any of these types of birth control **in the past**? (Circle all that apply)
- Tubes tied or blocked (female sterilization, Essure)
 - Vasectomy (male sterilization)
 - Birth control pills
 - Condoms
 - The Shot (Depo-Provera)
 - Contraceptive implant (a rod in your arm like Nexplanon)
 - Contraceptive patch
 - Vaginal ring (NuvaRing)
 - IUD with hormones (Mirena, Skyla, Liletta)
 - Copper IUD – no hormones (ParaGard)
 - Natural family planning (rhythm method)
 - Withdrawal (pulling out)
 - Not having sex (abstinence)
 - Decline to answer
 - I don't know
 - Other: Please specify _____
- 24) Are you or your partner currently pregnant or trying to get pregnant?
- Pregnant
 - Trying to get pregnant in the next year
 - Not pregnant or trying to get pregnant
- 25) Have you or your partner ever become pregnant at a time you were not trying or not expecting to become pregnant?
- Yes
 - No
 - Not sure
 - Decline to answer

-----Project Staff Only -----

Region: _____
 Referring Organization/Person: _____
 Focus group ID# _____
 Date of focus group _____

Appendix B

Young Women's Contraceptive Access and Experiences Focus Group Protocol

Overall Research Questions

1. What are female undergraduate students' views about and knowledge of LARC?
2. Which contraceptive methods do female undergraduate students find acceptable? Which methods do they not find acceptable? Why?
3. What are female undergraduate students experiences with accessing LARC? [If they use a LARC, how did they obtain it? What barriers (if any) did they face in obtaining a LARC device]
4. What are female undergraduate students' experiences using LARC? [How did they arrive at their decision to seek a LARC device?? To what extent do they experience LARC as enhancing or constraining their reproductive agency?

Materials Needed

- Chairs (enough for 2 facilitators and each participant)
- Drinking water for facilitators and participants
- Nametags
- Thick black magic markers to write on name tags
- Focus group recording equipment (2 digital recorders)
- Consent forms (copies for participants and facilitators)
- Sign up list for people who want to continue to receive information or attend an educational class (some may not sign until after the focus group when more trust is established)
- Business cards to give to participants
- Pens
- Clipboards
- Demographic surveys
- Large envelope to collect questionnaires
- Pad and pen for note taker
- Focus Group Guidelines on Flipchart

Focus Group Site Preparation (30 minutes)

1. Arrange chairs in circular formation for at least participants and two facilitators.
2. Have name tags and thick black magic markers available for participants to write their pseudonyms only.
3. Test audio recording equipment and place in center of the circle.
4. Warmly greet participants as they enter the room.
5. Give each young adult the verbal assent form to read over. Review the assent form and make sure they verbally assent to participate. Make sure each young adult knows they

can take the form with them. Be available to summarize/read the form to young adults that need help.

6. Administer the demographic surveys and have participants put the survey in the envelope when they are finished.
7. Ask participants to turn off cell phones.
8. Inform participants where bathrooms are and encourage them to use before the focus group gets started.

Introduction (5 minutes)

Good evening and welcome to our discussion. Thanks for taking the time to join us to talk about your perspectives and experiences related to long-acting methods of birth control. My name is _____ and working with me is _____. (Offer a little about your background.)

Background on Focus Group Research Study

I'm going to tell you a little bit about our project and what you can expect during our time together. Our focus group discussion is going to last about two hours total. Once we get started, I am going to ask you questions and we'd like you to share your thoughts and opinions freely. You will do most of the talking. We will be doing a lot of listening. Remember you are the experts and we want to learn from you. We are not going to necessarily "teach" you anything today but if you want to sign up for an informational session about contraception/LARC at the end of our discussion today, you will have the opportunity to do so. We will also distribute information sheets about contraception for you to take home with you.

How Today's Focus Group Will Work (5 minutes)

Talking about Sexuality Issues

We are going to be talking about birth control today, and specifically about long-acting reversible methods of birth control, which requires us to talk about sex and relationships. In our society, people don't always feel comfortable talking about sex openly and freely and we often don't have many opportunities to talk openly and honestly about sex and sexuality. Much of what we talk about tonight will be focus on issues that impact women who have sex with men, but we want you to know we realize not everyone in the group may identify as heterosexual or straight. We want to make sure that you feel safe and comfortable in this group talking about these kinds of issues. Here are some ground rules that will help make this group safe and comfortable:

- **No assumptions:** We won't make any assumptions about your behavior. We expect that there is a lot of diversity in this group. In general with young adults your age – some have already had some sort of sexual behavior, some have not. We are going to be asking you about your opinions and experiences and hope you will feel comfortable sharing.

- **Feelings are OK:** Because people don't have a lot of opportunities to discuss these issues openly, they sometimes feel a little uncomfortable, shy, or silly. All of these feelings are normal.
- **No judgments or put downs:** Please don't judge or put anyone down in the group because of something they say. In order for everyone to feel safe and comfortable, they have to know that no one is going to laugh at them, tease them, or put them down for anything they say today. So can we all agree that there will be no teasing or put downs? (look around for nods in agreement)

No "Right" or "Wrong" Answers and Participation

We'll be asking you some questions for the next two hours or so. There are no "right" or "wrong" answers to these questions because we want to know what you think. It's okay to have a different opinion from other people in the group. It's really important for us to hear all the different points of view in the room. We want you to share your point of view, whether it's the same or different from what others are saying. We want you to feel comfortable saying what you really think and to respect each other's opinions.

Don't feel like you have to respond to me all the time. Feel free to talk to one another when discussing my questions. If you want to respond to something someone said, agree or disagree with something someone said, or give an example, you can do that; just be respectful. We want all people to have a chance to share ideas. We may need to interrupt or call on people to make sure this happens. Please do not feel offended if we do this.

Recording and Confidentiality

We will be recording the session because we don't want to miss any of your comments. People often say things in these sessions and we can't write fast enough to write them all down.

We will use each other's pseudonyms today and again, we will not use your actual names in our report. No one will be able to link your identity back to what you said and only project staff like myself will listen to this recording. I am also going to ask all of you to keep what is said here confidential, so that everybody feels comfortable talking and knows what they say we will not be repeated. Can you all do that?" (Make eye contact with each person in the group and wait for her to nod affirmatively.)

Also, you do not have to answer any question that makes you feel uncomfortable. If you are asked a specific question and don't want to answer, you can just say 'pass.'

Timing

We expect to be here until _____. We appreciate you giving us your time and we want to make sure we end on time. _____ will be watching the clock and may need to interrupt the discussion at times and move us on to another question to be sure we have to time to discuss all topics.

Tell the group that you will be starting the recorder and do so.

[Begin recording]**Introductions [5-10 minutes]**

Let's begin. We have asked you to wear a name tag to help us remember each person's fake names. Let's go around the room and introduce yourselves by giving your pseudonym, your year at UT, and where you grew up.

Focus Group Questions**A. Learning about Birth Control [10-15 minutes]**

We are here today to talk about long acting reversible methods of birth control, which includes the intrauterine device (called the IUD for short) and the implant. There are specific brand names for these birth control methods such as the Mirena, Skyla, Paraguard (i.e., Copper IUD), and Nexplanon. We are interested in your views about and experiences with these birth control methods: if you have them, how you got them, if you tried to get one but couldn't, who influenced your decision to use or not use an IUD or an implant, and how you feel about them if you have one right now or had one in the past.

1. Think back to when you were growing up. What did you learn about birth control?
 - a. *Probe:* Who did you learn about birth control from? (i.e., School, from a parent, sibling, friends?)
 - b. *Probe:* Did you feel like what you learned about birth control was accurate? Did you feel like you had all the information you needed?
2. Now think about your time in college so far.
 - a. *Probe:* What (if anything) have you learned about birth control since starting college?
 - b. *Probe:* Is it different information than when you were younger? How so?
3. What is your main source of information about birth control right now?
 - a. *Probe:* Which websites have you used?
4. If you wanted to learn more about birth control methods, how would you do that?

B. Contraceptive Views and Experiences [30-45 minutes]

1. If you feel comfortable sharing with the group, what method of birth control do you currently use?
2. When you were deciding which birth control method to use, which kinds of options did you consider?

- A. *Probe:* How did you make this decision? Did you talk to anyone? Did you do research on the internet?
- B. *Probe:* If you have changed methods, why did you do so and how did you make this decision?

Thanks for sharing that with the group. Now let's talk about the IUD or intrauterine device first, then we'll talk about implants. Some of you are here because you have an IUD, or used to have an IUD, are thinking about getting an IUD or have tried to get an IUD. Let's talk about this birth control method and your views about them.

1. When did you first hear about the IUD? How did you learn about it?
 - A. *Probe:* What can you tell me about the IUD?
 - B. *Probe:* How long can the IUD last?
 - C. *Probe:* What can you tell me about the side effects of the IUD?
 - D. *Probe:* What can you tell me about their safety?
 - E. *Probe:* Who is able to get an IUD?
2. If you don't have an IUD but you wanted to get one, where would you go to get one? List places you know of.
3. If you have had or currently have an IUD, what is it like to have one?
 - A. Do you think about it?
 - B. Do you ever forget about it?
 - C. Do you experience side effects?
 - D. What are some negative side effects?
 - E. What are some positive side effects?
 - F. If you have an IUD, do you talk about your IUD with other people?
 - G. What is your sense of other people's opinions about the IUD? (Probe for views of parents, friends, partners, etc...)

Now we are going to talk about the implant.

4. Have you heard of the implant before? Sometimes it's referred to by its brand name, either Nexplanon or Implanon.
 - A. What can you tell me about the implant?
 - B. How long can the implant last?
 - C. What can you tell me about its side effects?
 - D. What can you tell me about its safety?
 - E. Who is able to get an implant?
5. If you don't have an implant but you wanted to get one, where would you go to get one? List places you know of.
6. If you have an implant, what is it like to have an implant?

- A. Do you think about it?
 - B. Do you ever forget about it? Do you experience side effects?
7. If you have an implant, do you talk about your implant with other people? Do you have any sense of other people's opinions about implants?
 8. Did you experience any specific obstacles when you tried to get a specific method of birth control?
 - a. *Probe:* Did anyone try to discourage you from getting an IUD or an implant?
 - b. *Probe:* Did anyone encourage you to get an IUD or an implant?
 9. If you have never used an IUD or implant, would you consider using either an IUD or an implant in the future?
 - A. *Probe:* Why or why not? Is one method more appealing than the other? How so?
 - B. *Probe:* What would you need to know about these methods to change your mind?

C. Birth Control and Relationships [20-30 minutes]

Thanks for sharing all of that. Now we are going to talk about birth control in the context of sex and relationships.

1. What do you think is important to young women when choosing a method of birth control?
2. If you are sexually active, have you ever talked with your partner or partners about birth control? That could include a boyfriend, a guy you're hooking up with, or any other kind of sexual relationship you may have.
 - a. *Probe:* Do they know about the birth control method you are currently using? What do they think about it?
3. How involved do you think men should be when it comes to birth control?
4. Is there anything that would make choosing a birth control method easier for you?
 - a. *Probe:* What information do you wish you had when deciding on a birth control method?
 - b. *Probe:* Is there some kind of tool or resource that would be helpful for choosing a method?
5. What is your impression of which contraceptive methods other people like you are using? Do you think a lot of people your age use the IUD or the implant? Why or why not?
6. We appreciate you sharing your views on birth control. Is there anything you would like to add to what we've talked about tonight?

Wrap Up [5 minutes]

Our time is coming to a close and we want to thank you so much for taking the time to participate in the focus group. We realize that our conversation tonight may have raised more questions than it answered for you so if you all would be interested in attending an educational class about different birth control methods, please make sure you fill out the white card with your name and contact info (phone number and email) and put it in the envelope.

If you have not already put your completed questionnaire in the envelope, please do so before you leave today.

Thanks again for sharing your insights today!

(Make sure all participants turn in completed questionnaire)

VITA

Elena Schuch was born in Delray Beach, FL, to the parents of Dr. Rosa Romigosa and Christoph Schuch. She attended an International Baccalaureate program for high school, followed by the University of Florida in Gainesville. She received her Bachelor's in psychology with a minor in French in 2014. During her undergraduate years, Elena studied abroad in Paris, France for a semester at the Sorbonne. After graduating, she served for two years in the Peace Corps in Burkina Faso, West Africa, with an emphasis on health education. In the fall of 2017 Elena began the Counseling Psychology doctoral program at The University of Tennessee, Knoxville, studying with Dr. Patrick Ryan Grzanka.