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The US in Uterus: A Collaborative Autoethnography of Psychologists Advocating for Reproductive Justice

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Abstract

In light of the recent Supreme Court decision to overturn *Roe v. Wade*, millions of people with uteruses have been forced to navigate precarious access to reproductive care. Although health service psychologists have an ethical responsibility to engage in reproductive justice advocacy, training programs often do not adequately address sexual and reproductive health. Therefore, we sought to better understand how health service psychologists' personal and professional experiences influence each other and explore the ways in which we as reproductive beings and advocates

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This article appeared in a special issue, "Reproductive Justice: Advancing Science, Advocacy, and Practice," published in the *Psychology of Women Quarterly*. Laurel B. Watson, Candice N. Hargons, and Debra Mollen served as guest editors of the special issue.

sustain ourselves amidst tremendous sociopolitical uncertainty. In order to do so, we employed a feminist collaborative autoethnography approach grounded in critical theory. Attending to intersectional identities that help shape diverse expectations and experiences, two early career psychologists and four trainees uncovered 12 domains: barriers in academia; reproductive (dis)empowerment; relational connection; power(lessness) associated with social locations; internalization of sex-negative messages; the influence of sociopolitical climate; burdens related to reproductive rights; evaluations of reproductive justice efforts; component of professional identity; expectations from family and community; overwhelming and exhausting advocacy; and fears of inadequacy. We conclude with limitations and implications for the continued promotion of advocacy through practice and training within and beyond the field of psychology.

Keywords: reproductive justice, advocacy, privilege, collective autoethnography

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Health service psychologists (HSPs) work in diverse settings, integrating psychological science and clinical practice to support wellness (American Psychological Association [APA], 2015). Competence in health service psychology includes attending to individual and cultural diversity and integrating a social justice framework and advocacy into our professional work (Fouad et al., 2009; Hatcher et al., 2013). Reproductive justice (RJ), or the human right to maintain personal bodily autonomy, have children, not have children, and parent children in safe, sustainable communities (SisterSong, 2022), resists laws and policies that use race-, class-, and gender-based oppression to interfere with reproductive decision-making and, in turn, the public's health and safety (Ross & Solinger, 2017). Although abortions have long been inaccessible and criminalized for low-income people and people of color with uteruses, the overturning of federal protection for abortions (*Dobbs v. Jackson Women's Health*) in 2022 represents an assault on RJ that will have far-reaching, devastating consequences for the communities that HSPs serve. Thus, HSPs engaging in RJ advocacy are aligned with liberation-centered, public-facing psychology (Neville et al., 2021).

Despite the need for an informed and prepared health service psychology, opportunities for advocacy education are limited (Alexander & Allo, 2021) and sex and reproduction are infrequently addressed in training programs (Abbott et al., 2021; Abbott et al., 2022; Mollen et al., 2020). Therefore, even among HSPs committed to the integration

of RJ in their work, it is unclear the extent to which they feel prepared to operate as activists and change agents for RJ. Additionally, among racial justice activists of color, advocacy challenges (e.g., burnout) occur as a result of elements of the advocacy itself (e.g., fighting against systems of power, low wages) as well as racial battle fatigue, or the cumulative effect of everyday experiences of racism (Gorski, 2019). Thus, RJ advocacy may mirror this experience in activists with uterus who navigate challenges related to their advocacy in tandem with experiences of structural violence in their personal reproductive lives, a phenomenon this collaborative autoethnography sought to explore among HSPs and HSP trainees. Of note, this paper aimed to use inclusive language and referred to any individual with a uterus as “people with uteruses” or similar to acknowledge the relevance of reproductive injustice irrespective of gender identity.

Advocacy in Health Service Psychology

The APA has a long-standing history of engaging in advocacy and shaping public policy. In the mid-20th century, APA (1956) created a resolution dedicating the organization to advancing human welfare through science-based psychological knowledge. Since then, APA and its members have played a part in creating governmental policies, initiatives, and programs at state and federal levels that address social issues and increase access to services that positively impact psychological health (Garrison et al., 2017). One of APA’s objectives is to advance the profession and science of psychology in the interest of serving the public through health promotion. Further, APA’s strategic plan outlines a goal of increasing the organization’s impact on social welfare advocacy (APA, 2019). This objective and organizational goal implores the organization, and its members, to advocate for the people they serve, making advocacy an essential aspect of professional psychology. We have an ethical duty and right to advocate in the political process, especially when a policy is under the purview of our expertise as a field. In the case of RJ, APA reaffirmed its commitment in 2022 (APA, 2022a) and provides numerous resources for the public and its members related to reproductive health education (APA, 2022c) and advocacy (APA, 2022b). Historically, the advocacy carried out by APA is most effective when members are actively engaged with

an issue (Garrison et al., 2017), highlighting the importance of individual psychologists and graduate students' involvement in advocacy and political action. In line with the centrality of advocacy in psychology, Neville et al. (2021) proposed a liberation-focused training model for developing expertise and lifelong practices among HSPs to create a responsive public psychology skilled at addressing societal injustices and oppressions.

Advocacy Preparation for HSPs. Despite this rich history of advocacy, many health service psychology graduate training programs offer little-to-no education in advocacy, social justice, or influencing public policy (Alexander & Allo, 2021). Within the field of counseling psychology, there are three APA-accredited doctoral programs that have specific training and practica experiences for social justice and advocacy (Hage et al., 2020), making up less than 1% of all APA-accredited psychology doctoral programs. The absence of consistent and accessible advocacy training suggests most graduate students and HSPs are ill-prepared to integrate advocacy into their professional practice.

Vera and Speight (2003) called for the field of psychology to move from offering primarily individual interventions to multisystemic efforts grounded in social justice and aimed at addressing systemic issues. Since this call for action, several counseling psychologists have called for graduate-level training in practical social justice and advocacy skills (Goodman et al., 2018; Pieterse et al., 2009). Additionally, graduate students in counseling psychology have repeatedly expressed interest in this kind of training (Baranowski et al., 2016; Beer et al., 2012); many of these students reported seeking outside training on advocacy, despite financial and relational burdens (Singh et al., 2010). The lack of training in advocacy leaves graduate students vulnerable to overextending themselves and their resources in order to fill an experience gap that graduate programs could offer to students. As students matriculate and become professional HSPs, they may still lack the skills necessary to sustain themselves in advocacy work, leading to burnout and the passing down of unsustainable advocacy practices to students they may mentor.

Advocacy Burnout. Burnout is a phenomenon that presents as emotional exhaustion, depersonalization (Killian, 2008), lowered

self-efficacy (Stebnicki, 2007), and a decreased sense of individual accomplishment (Clark et al., 2009). It occurs in reaction to prolonged stress (Wardle & Mayorga, 2016) and is associated with many physical and mental health problems (Ahola et al., 2007; Vlăduț & Kállay, 2010), contributing to a poorer quality of life (Chang, 2014). APA acknowledged in their definition of burnout that it is commonly observed in “professionals who work in service-oriented vocations” (APA, 2023a, para. 1). For mental health practitioners, in particular, burnout is harder to treat (Dreison et al., 2018). One study found that roughly 13% of all mental health practitioners were at risk of burnout and/or compassion fatigue (Sprang et al., 2007), and another found that 49% of mental health trainees were actively experiencing burnout (Kaeding et al., 2017). Similar to burnout, APA defined compassion fatigue as “the burnout and stress-related symptoms experienced by caregivers and other helping professionals in reaction to working with traumatized people over an extended period of time” (APA, 2023b, para. 1). Graduate school is often where burnout and compassion fatigue can begin for counselors-in-training (Thompson et al., 2011; Wardle & Mayorga, 2016). Burnout in mental health practitioners reduces their overall effectiveness and competence in providing services to clients (Bearse et al., 2013; Puig et al., 2012).

Advocacy efforts range in the level of involvement required and associated risks, however, they can negatively impact people’s well-being and mental health, regardless of these factors. At its core, advocacy is about pursuing and protecting the rights of others, and often those doing this work neglect their mental health and well-being in the process. In a study of human rights advocates, 19.4% of participants met diagnostic criteria for post-traumatic stress disorder (PTSD), 18.8% showed sub-clinical PTSD symptomology, 14.7% met criteria for major depressive disorder, and 19% were experiencing burnout (Knuckey et al., 2017). HSPs and trainees may or may not be actively experiencing or witnessing trauma related to their advocacy work; however, it is well-established that vicarious trauma and burnout accompany the clinical work in which they engage (Jenkins & Baird, 2005). Thus, HSPs and trainees are at risk of experiencing burnout and/or mental health concerns related to the compounding effects of advocacy and clinical work, particularly in the absence of formal advocacy training that could foster resilience.

Reproductive Justice

RJ (SisterSong, 2022) has become increasingly politicized as legislators have attempted to limit access to contraception and criminalize abortion (Pugh, 2019). Despite progress toward ensuring reproductive rights in the 20th century (Gozdecka, 2020), feminist discourse has faced significant backlash over the course of the past two decades culminating in the 561 antiabortion state laws introduced in the first 6 months of 2021 (Nash & Cross, 2021) and the overturning of *Roe v. Wade* in June 2022, leaving determinations about the legality of abortions to states (*Dobbs v. Jackson Women's Health*, 2022). These restrictive policies pose dangerous implications for the physical health and psychological, political, economic, and social well-being of people with uteruses (Fried, 2013; Ross & Solinger, 2017). Further, RJ represents an integral component of a holistic, integrated approach to liberation that requires attending to all structural conditions (e.g., racism, heterosexism, ableism) that seek to control our bodies, our sexualities, and our reproductive lives (Ross & Solinger, 2017).

BIPOC (Prather et al., 2018), LGBTQ+(Price, 2018), and rural-residing and low-income people (Jerman et al., 2016) are disproportionately and negatively affected by reproductive injustice and restrictions on abortions. For example, women of color are more likely to be criminalized and/or forced to undergo medical procedures for alleged fetal harm, and the overturning of *Roe v. Wade* is likely to exacerbate this danger (Paltrow et al., 2022). Rural pregnant people, in the face of inaccessible abortion services and low levels of social support, often continue unwanted pregnancies with deleterious consequences for their economic and psychological health (O'Donnell et al., 2018). Queer people face challenges with regard to accessing assisted reproductive technologies or paths to adoption (Lane, 2019). Thus, people without institutionalized power (e.g., immigrants, people with disabilities) are particularly vulnerable to the harm of reproductive injustice (Ross & Solinger, 2017).

RJ and Health Service Psychology. HSPs' many roles, including clinician, supervisor, researcher, educator, and consultant, offer ample opportunities to employ an RJ framework in the interest of addressing the aforementioned consequences of reproductive injustice among the

public they serve. Unfortunately, psychology as a field has been slow to adopt an RJ framework (Chrisler, 2012), in part due to the manner by which it would problematize the way psychological research has historically been conducted, forcing researchers to consider systems and power rather than focusing on individual, primarily Western, experiences (Eaton & Stephens, 2020). Likewise, in the absence of sexual and reproductive wellness education in HSP (Abbott et al., 2021; Abbott et al., 2022; Mollen et al., 2020), HSP trainees feel ill-equipped to address sexual issues, including reproduction, across their roles (Hanzlik & Gaubatz, 2012); in turn, supervisors and faculty in HSP programs lack sexual and reproductive health knowledge and do not address sexual and reproductive health in the training they provide, creating a cycle in which each cohort of HSPs is inadequately prepared to address sexual and reproductive health and RJ (Abbott et al., 2022). Shifting the field of psychology towards an RJ framework must happen at a systemic level so that all HSPs are equipped, knowledgeable, and equitable in their work related to reproductive rights and justice.

By contrast, an RJ-informed health service psychology would acknowledge how people's experiences and identities impact their ability to safely and freely choose when, how, and/or if they reproduce (Grzanka & Frantell, 2017; Luna, 2016), prioritize autonomy and the ability to make choices in one's sex life, drawing vital connections to issues of sexual assault and sex trafficking (Chrisler, 2014) and strengthen access to reproductive healthcare and sex education for all people, regardless of their identities or beliefs (Mollen & Abbott, 2021)—issues that are unarguably integrated into the work psychologists do. Broadening RJ to these levels shows the integral nature of this framework and reifies the notion that RJ is not a “women's” issue but instead is something that affects everyone at various times in their lives.

The Present Study

HSPs are well-positioned to play an important role in the fight for RJ in the United States and are ethically bound to help at both the individual and systemic levels (Grzanka & Frantell, 2017). Further, as the RJ framework was developed by members of the Global Majority, who are most impacted by structural reproductive injustice, it is a cogent

fit for a liberation-centered approach to public psychology that promotes equity and healing (Neville et al., 2021). However, it is unclear to what degree, if at all, HSPs and HSP trainees are able to enact RJ advocacy given the current state of the field and how those with uterus experience engaging in RJ advocacy in their professional work as people directly impacted by oppressive violations of their personal reproductive rights, a gap this study seeks to begin to address. Guided by a critical, feminist framework (LaFrance & Wigginton, 2019), our collaborative autoethnographic study was informed by the following research questions about HSPs and HSP trainees with uteruses:

1. How, if at all, do our personal reproductive lives and professional RJ advocacy influence one another?
2. How do we sustain ourselves in the fight for RJ?

Method

Our study was underpinned by critical theory (Kincheloe & McLaren, 1994), acknowledging that all interpretations are political acts (Esposito & Evans-Winters, 2022). These interpretations are aligned with our intention to position the experiences of HSPs and HSP trainees within the complex matrix of privilege and oppression in which they exist (Cole, 2009) and our aim to provide recommendations for HSPs to operate as change agents for RJ. In particular, we were aware of the ways in which intersectionality (Crenshaw, 1989), or the manner by which combinations of cultural positionalities uniquely influence people's lives, shapes embodied experiences. Autoethnography provides the opportunity to access our intersectional knowledge in the interest of transforming systems and resisting domination (Esposito & Evans-Winters, 2022) and collaborative autoethnography facilitates the uncovering of collective wisdom. Therefore, we utilized a feminist collaborative autoethnography approach (Rutter et al., 2021), employing intersubjectivity and honoring that HSPs are in the community and that our individual and mutual experiences are valuable sources of data that may benefit our community. Congruent with our critical feminist approach, collaborative autoethnography guided a communal self-interrogation process in which power was shared among

researcher-participants (Chang et al., 2013), in the interest of uncovering our embodied knowledge (Jones, 2016).

Participants

The study included six trainees or faculty members in health service psychology, specifically counseling psychology. Small sample sizes are typical of collaborative autoethnography projects as they facilitate group meaning making (Hargons et al., 2017; Hernandez et al., 2015). The group consisted of a research advisor and current and former student members of the advisor's research team at a large, research-intensive Midwestern university. We all received or were receiving, our doctoral training from three different APA-accredited counseling psychology training programs located in the Southern and Midwestern U.S. The two faculty team members supervised masters and/or doctoral-level clinicians and provided counseling in independent practice or university counseling services during the execution of the current project. Additionally, each of the current student members is receiving clinical training and is providing counseling in various settings (e.g., campus clinic, telehealth, outpatient). Three of us had training and experience in conducting qualitative research using similar paradigms and analyses. For those for whom this was their first qualitative project, some had taken qualitative coursework prior or concurrent with this study and all were mentored by the first and other authors throughout the process. The team met once prior to the onset of the study to discuss the intimacy and vulnerability involved in a collaborative autoethnography project, particularly related to our sexual and reproductive lives. We processed together the nature of the project, asked questions, stated concerns, and considered modifying the team given the first author's evaluative role with some team members. After 2 weeks of consideration, in a second meeting, all team members ultimately decided to move forward as contributors, and all consented to the first author's involvement.

Given the researchers are the participants, demographic characteristics we were comfortable publicly sharing are outlined in **Table 1** along with pseudonyms. Some characteristics such as age and racialization are presented in broad terms in the interest of privacy. Two members of our team were early career faculty members and four were doctoral graduate students and candidates.

Table 1. Positionality of Researchers.

<i>Pseudonyms</i>	<i>Salient Identities</i>
Angela	Person of color, bisexual, cisgender woman and daughter, able-bodied, raised and socialized in a working-class family and community, child-free, 20 s
Glennon	White, heterosexual, cisgender woman, able-bodied, working-class background, doctoral student, child-free, 20s
Gloria	White, heteroflexible, cisgender woman and mother, able-bodied, raised and socialized in a working-class family and community, 30s
Jessica	Person of color, heteroflexible, non-binary, able-bodied, raised and socialized in a working-class and immigrant family and community, child-free, 20s
Mary	White, bisexual, cisgender woman, disabled, raised in an upper middle-class family and community, child-free, 20s
Ruth	White, heteroflexible, cisgender woman and daughter, able-bodied, raised in a working-class family and community, child-free, 30s

Sources of Data

We employed a full, concurrent collaboration model in which all members were involved at every stage of the study and data was generated individually and shared collectively (Chang et al., 2013). The primary data for this study were individual narratives written by each author. Before the construction of these narratives, over the course of two meetings, the team crafted a series of prompts driven by our research questions to guide our narrative writing (see Appendix). The process was iterative in that we alternated between individual and group processes in the interest of narrowing our focus (Chang et al., 2013), engaging in a discursive process (Kamberelis et al., 2018), and deepening our self-reflection. In response to some team members' desire that their first draft not be reviewed by the entire team, we reviewed first drafts and provided feedback to one another in dyads. Partners provided each other support, noted powerful components of one another's stories, and probed for elaboration.

Then, the group met together to process the writing of our narratives and reviewing of their partner's narratives. During the group meeting, we agreed to revise our drafts by addressing our partner's feedback, making more explicit connections between our personal

reproductive experiences and our professional work, and including more about how we were advocating for RJ and how we were sustaining ourselves, or not. We also agreed that all team members would read all narratives prior to our next team meeting. In a second team meeting following the completion of our revisions, we continued discussing the reflective process of writing our narratives, what changed for us, if anything, between drafts, and what common experiences or themes we identified across narratives. We collaboratively agreed that our second drafts adequately addressed our research questions and constituted our final narratives. The resulting six narratives ranged from 1,843 to 8,181 and totaled 30,139 words. Our two group meetings were 62 and 73 min in duration, respectively. The two group meetings were recorded and auto-transcribed by a videoconferencing platform, after which the second author deidentified and cleaned the transcripts.

Data Analysis

Aligned with our full collaboration model, we employed consensual qualitative research (CQR) methods in analyzing our data. CQR's constructivist roots, honoring the ways in which reality is socially constructed, and emphasis on consensus (Hill & Knox, 2021) are a cogent fit for our critical, feminist collaborative autoethnography approach. Roles were determined collaboratively with our respective strengths, comfort, and experience in mind; efforts were made to have a team member with more experience paired with a team member with less experience for each task. The first and second authors were primary coders, the fourth and sixth authors were auditors, and all authors engaged in team consensus meetings. The first author served as a primary, internal auditor, offering supervision and mentorship at each stage of the data analysis. The coders immersed themselves in the narratives through multiple readings. Again, using an iterative process, we coded, audited, and then discussed to consensus across three stages: domains, core ideas, and cross analysis, or the generation of categories (Hill & Knox, 2021). In the final cross-analysis stage, we each developed categories of core ideas for each domain. In a team meeting, we shared the categories we developed, identifying common categories and discussing consensus on the formation of categories with discrepant descriptions across team members. Once in agreement

across all domains, in dyads, we finalized category names, identified powerful quotes within domains, and summarized each domain. The narratives and codebook derived from the narratives served as the primary data source, whereas transcripts of group meetings were utilized as complementary data to contextualize our process and enrich our findings.

Results

Below we begin with a descriptive-realistic approach, in which we offer detailed descriptions of the process of generating our stories primarily informed by our team meetings followed by an analytical-interpretive approach, outlining the findings of the CQR analysis of our narratives (Chang et al., 2013). Our data analysis resulted in 12 domains, outlined in **Table 2** along with the categories that comprise them and frequency descriptors. Below, domains are presented in order from the domain coded most frequently across all six narratives to the least coded domain included in some, but not all, narratives.

Team Meetings

Of note, *Dobbs v. Jackson Women's Health* (2021) was decided after or during the completion of our first drafts and significantly influenced our writing and group process. In the first team meeting, Angela described the "painful" process of generating her narrative and Gloria pointed out the timing and challenge of writing in the wake of the overturning of *Roe v. Wade*. Glennon described writing in the wake of *Dobbs* and the "hopelessness" of her narrative; Ruth concurred, recalling feeling "defeated." An important and powerful dialog about the team members' respective social locations and associated privileges resulted. This dialog challenged some members' despondency and shifted their sense of agency regarding RJ. Gloria and Glennon acknowledged that, given their privilege as White women, they had never felt as "devalued" as in the moment the *Dobbs* decision was announced. Gloria commented that the "hope" in Angela's narrative was in stark contrast to her own and alerted her to how "hopelessness may be a reflection of that privilege." Angela, too, was aware of

this difference in the narrative and noted, “As a Black woman, I have to have that hope.” Thus, the diversity in our life experiences, and our trust in one another to hold such conversations, was integral in deepening our awareness and critical analysis of the personal narratives we sought to develop and our individual processes in the wake of Dobbs.

Likewise, reading others’ narratives increased our awareness of those messages about our reproductive lives that were “ingrained.” For example, Mary’s discussion of thin privilege prompted Ruth to think about how “living as a large person ... shaped [her] interactions with doctors and [her] own reproductive health.” Team members found others’ emotional reactions (e.g., anger, sadness) to their stories validating; Gloria noted how others’ anger about her negative reproductive experiences highlighted “how accepting [she] was of the status quo.” A notable commonality across stories discussed in our team meetings was feelings on “inadequacy” with regard to our RJ efforts, to which Glennon responded:

I was just listening to a podcast and it was talking about how women are taught to think either they’re too much or too little and I feel like that feels like part of this. Because there’s men in our field and people with penises and I don’t know that they feel the same anxiety and guilt around doing too little. I think women across the field, there’s always something that they are like, “Oh, I could be doing more.”

Despite these candid conversations, team members reported attending to their own and others’ comfort within our discussions, and this interpersonal dynamic was replicated in their RJ advocacy. Jessica acknowledged that in her writing and dialogs with the team, she was “polite” to avoid hurting others and wondered if [she] were, in turn, “diminishing [her] own story.” Ruth wondered, “Why do we have to make these things and these events that have taken away our autonomy, our power, ourselves to be more pleasing or less uncomfortable for other people?” These dialogs informed the revisions of our narratives and future discussions, such that we acknowledged the obstacles we faced as people with uteruses and advocates for RJ and intentionally attempted to push against our discomforts to provide accurate narratives of our experiences.

Table 2. Domains and Categories.

<i>Domains</i>	<i>n</i>	<i>Codes</i>	<i>Categories</i>	<i>Frequency</i>
Barriers in academia for RJs and people with uteruses	6	80	Absence of formal training in RJA Fear of engaging in RJA due to potential retaliation Gendered barriers in academia for RJs and people with uteruses Invalidations of reproductive lives in clinical work Obstacles to parenting in academia Racialized barriers in academia for RJs and people with uteruses	Typical Variant General Variant Variant Rare
Experiences of (dis)empowerment	6	68	(Fears of) pregnancy responsibility within personal and professional life Affirming experiences Challenges to bodily autonomy Invalidating interpersonal experiences Lack of access to reproductive healthcare Negative experiences with medical professionals Traumatizing experiences of sexual assault	Variant General Variant Variant Typical General Variant
The rewards of relational connections	6	55	Community fostered through shared experiences Healing and growth through relationships Solidarity with people who value reproductive freedom	General Variant Typical
Power(lessness) associated with social locations	6	51	Access to reproductive justice and racialized experiences The benefits of privilege The transformative influences of education	Variant Variant General
Internalization of sex-negative messages	6	48	Early experiences of reproductive silence, shame, and isolation Long-term impact of sex-negative messages Sexual and reproductive health lessons rooted in patriarchy Sources and descriptions of sex-negative education	Variant Variant Typical Typical
The influence of sociopolitical climate on reproductive choices and RJA	6	47	Impact of policy and cultural change on access to reproductive healthcare Systemic understanding of reproductive injustice The influences of elections on sense of reproductive safety and autonomy	General Variant Variant

<i>Domains</i>	<i>n</i>	<i>Codes</i>	<i>Categories</i>	<i>Frequency</i>
Carrying burdens related to reproductive rights	6	42	Burden of educating others who perpetuate reproductive injustice	Typical
			Impacts of identity on reproductive health decision-making	General
			Negative impacts of reproductive burdens	Typical
Evaluations of past, current, and future efforts in the fight for reproductive justice	6	24	Sole responsibility for preventing negative reproductive health outcomes	Typical
			Hopeful beliefs about reproductive justice advocacy	Variant
			Reactions to Dobbs v. Jackson women's health decision	Variant
RJA as a component of my professional identity	5	44	Sense of ineffectiveness as a reproductive justice advocate	Variant
			Professional=personal=political	General
			Reproductive justice advocacy and clinical practice	Variant
Expectations from family and community about reproduction and parenting	5	33	Reproductive justice-informed education and mentorship	Typical
			Family views and values	General
			Importance of education	Variant
Advocacy as overwhelming and exhausting	5	24	Influence of familial background	Variant
			Motherhood expectations	Variant
			Lack of self-care	Variant
Fears of inadequacy as a RJA	4	32	Negative emotional responses	General
			Feelings of incompetence	Typical
			High expectations or perfectionism	Rare
			Limits of impact of work	Typical

Note. RJA=reproductive justice advocacy/advocate. Category frequencies are as follows: General=5-6, Typical=4, Variant=2-3, Rare=1.

Domains

Barriers to RJ in Academia for People with Uteruses. We ($n=6$) described specific challenges we faced in academia as people with uteruses and advocates. In formal training ($n=4$), Angela noted a “lack of integration” of advocacy skills. A few of us ($n=3$) shared a fear of advocating for RJ as a part of our academic work due to potential retaliation, worrying about negative impacts on our careers, or harming relationships with colleagues. In addition to barriers to advocacy, we identified barriers related to our personal reproductive lives we described as gendered ($n=5$) and racialized ($n=1$). For example, Ruth wondered if her regret for prioritizing education over parenthood would be present “if [she] didn’t have a uterus.” Angela perceived isolation in a “homogenous” environment favoring “White men with families.” Gloria shared difficulties in balancing parenthood and training. Clinical work often intersected with personal sexual and reproductive histories ($n=3$); for example, Mary described “flashbacks” upon hearing clients’ stories of sexual assault. In sharing the experience of learning *Roe v. Wade* was overturned while practicing assessment skills, Glennon spoke to the difficulty of balancing womanhood and training:

How did everyone in the building I was in hold in the guttural sob I would later let out in my car once I was able to let myself feel what was happening? This is what it means to be a student and psychologist-in-training. While my literal right to my body was deemed as not a constitutional right ... I had to pull myself together, hold in my emotions, and continue on with things that I now question if they even matter in the grand scheme of things as if my humanity had not just been questioned by some of the biggest stakeholders in the country.

Experiences of Reproductive (Dis)Empowerment. Outside of academia, we most often described disempowerment in our reproductive lives, though empowering exceptions were noted ($n=6$). Invalidation from reproductive health professionals ($n=5$) and lack of access to care ($n=4$) were common. Before a procedure, Mary was “interrogated”

about her sexual life by a team of male medical professionals. Jessica was “disappointed” by the “gatekeeping” of reproductive health care and knowledge. Others’ disempowerment presented in the form of fears of pregnancy ($n=2$), invalidations of their bodily autonomy ($n=3$), unaffirming interpersonal experiences ($n=3$), and sexual assault ($n=3$). For example, Gloria recalled “immediate panic” in thinking about the “responsibility of parenting.” Angela’s mother and doctor pressured her to take birth control. However, most participants ($n=5$) identified an example of empowerment as well. Angela “reclaimed” her power through reproductive health education. Gloria described her professional training, in particular, as “healing” after a pregnancy loss. Ruth grew in self-compassion after sexual assault:

I do not blame myself. I do, however, apologize to myself for the men who chose to take power from me in that moment. I learned that I am more willing to forgive myself for the assaults that happened to me than I am the people that did them to me.

The Rewards of Relational Connection. All six of us described ways in which being in connection with others sustained us in our reproductive lives and advocacy. This connection encompassed shared experiences and identities with peers, colleagues, and clients ($n=5$) and solidarity in values ($n=4$). Some of us were energized by attending protests and engaging in advocacy work with others similarly harmed by the ongoing attacks on reproductive rights; Gloria remembered one such protest as “a lovely memory of solidarity and a rare moment in which it felt our work was paying off in a meaningful way.” Others ($n=3$) recounted how the supportive environments of their training programs offered safe spaces to grow through tremendous hardship and loss. Within her program, Mary described solidarity as “an incredibly uplifting and inspiring experience” that sustained her ability to continue engaging in RJ advocacy:

I have been guided by someone who’s trained to educate others about sex, befriended someone who advocates for pleasure, and supported by someone who has the calming presence to sit with the grief of sexual violence. I wasn’t raised in

a family that talked about sex, but I feel so grateful that my “chosen family” in grad school has met these needs I didn’t even know I had.

Power(Lessness) Associated with Social Locations. All of us ($n=6$) described various identities and privileges that impacted our experience as people with uteruses and advocates. Frequently cited ($n=6$), education provided the impetus for growth in participants’ knowledge and capacity for engagement in RJ advocacy. Our (under)graduate training deepened our understanding of social positionalities and core beliefs; Ruth described how “in these classes and spaces [she] really started to form who [she was] as a feminist (womanist).” Three of us noted the role of education in unraveling the conservative belief systems ingrained from their working-class backgrounds. Glennon expressed frustration that these traditional, meritocratic values were designed to teach people not to “dare to imagine a world in which you have choice, freedom, and liberation.” For others ($n=4$), their racialized identities informed the degree of their experiences of marginalization as people with uteruses. Specifically, three White team members explained how they benefited from the buffer of Whiteness in their experiences of navigating gynecological care, while Angela, a woman of color, described her fear of maternal mortality as a result of her socialization to the harsh reality that as a Black woman, “no amount of class and light [skin] privilege can save [her] from death.” Two of us described how before the release of the Dobbs decision to overturn *Roe v. Wade*, their White privilege shielded them from feeling disempowered as women of color have felt for generations in that their decisions were no longer theirs to make. Gloria voiced:

When Dobbs was officially decided and *Roe* was overturned, even though I knew it was coming, I didn’t immediately feel anger—I felt intense grief. In my life, as a White cis- woman, I have never felt so devalued. What an immense privilege to go [many] years without that sensation. I realize that’s not at all true for so many—particularly women of color, Black women, and indigenous women, trans and gender expansive folk, people with disabilities, and others.

Internalization of Sex-Negative Messages. We all ($n=6$) described negative messages about sex and reproduction early in our lives that influenced our personal reproductive lives and required unlearning in adulthood. The most common of these were inaccurate or insufficient education about sex and reproduction ($n=4$) and gendered messages that limited the sexual and reproductive lives of girls, women, and people with vulvas ($n=4$). For example, Gloria noted her sexuality education in youth was “entirely heteronormative.” As a girl, Mary learned that sex was “dirty and violating and clandestine” and that her “body could be useful to men long before [she] knew [she] had sexual and reproductive rights.” Others described the silence around sex in their communities or families; Jessica reported “zero discussion” about sex in her childhood home, noting “children simply appeared, and there was no explanation as to why.” Two of us explicitly provided examples of the long-term impact of these sex- and reproduction-negative messages. After recounting some harmful messages she received as a young person, Jessica shared:

All of these brief moments are what fostered my views and interests in reproductive justice today. I have been withheld information. I have been taught that my sexuality and reproductive health was a topic of shame and secrecy ... I have received more than enough negative messages from society regarding the consequences of my reproductive choices, or lack thereof, throughout my lifetime.

The Influence of Sociopolitical Climate on Reproductive Choices and Advocacy. Most of us ($n=5$) identified ways in which access to our preferred reproductive health care was limited in the course of our lifetime. Jessica recalled the possibility of pregnancy and needing to “double-check” the legality of abortion in her state and “pulling up a list of states where abortion was legal” due to the fast-changing restrictions across the country. Describing her decision to prevent pregnancy using an intrauterine device, Glennon said:

I chose it for one reason only—the length of use. This birth control lasts 10–12 years and I remember telling my provider I wanted this one because “I might have to make it through

two presidential terms with ongoing threats to my reproductive rights.”

Like Glennon, several of us ($n=3$) referenced how federal elections were critical to our personal reproductive lives and engagement in advocacy. Addressing her fury with people who voted for candidates that opposed reproductive freedom, Gloria was “reminded of the intense and unhealthy individualism that runs rampant in U.S. culture.” Similarly, Mary resented that “Roe was not codified” and was “being used as a fundraising chip by the very people who claim[ed] to be on [her] team.” Some ($n=3$) tied these experiences to the systems of oppression that perpetuated them (e.g., misogyny, anti-Black racism). Angela was “frustrated in a lack of awareness that reproductive control holds roots in racial oppression” and Mary was pained by watching “women spill their most painful, traumatic stories to beg that their autonomy as human beings is recognized.”

Carrying Burdens Related to Reproductive Rights. All of us ($n= 6$) described feeling burdened by the responsibility to protect our own and others’ reproductive freedom. Most ($n=5$) described particular parts of our lived experience (e.g., age, racialization) that complicated our reproductive decision making. For example, Angela feared “maternal mortality” and “raising Black, biracial children.” Gloria’s professional roles made it difficult to “step back” from the “awfulness” of reproductive injustice in order “to grieve and care for [her]self.” Four of us also saw these decisions and the protection of our reproductive lives as unfairly their sole responsibility, despite the shared responsibility of male partners and policymakers. Ruth noted the task of preventing unplanned pregnancy, for example, was “fully on the person with the uterus.” Some ($n=4$) also described the negative impacts of such burdens, including the “loss of possibility” and “fear of being shamed.” Notably, more than half of us ($n= 4$) noted the specific burden of educating others about RJ who often lacked understanding, were uninterested, or unwilling to learn. Jessica expressed the difficulty she experienced in attempts to share her knowledge with the community:

It has often become so extremely frustrating, involving a lot of hard emotional labor. I often find myself overflowing with immense emotions when I hold these conversations. I am terribly disappointed by [others'] ignorance on the topic. I find myself so frustrated by many individual's selfish ways of thinking and their inability to consider and to empathize with another individual's circumstance. I am also so frustrated by their lack of action to support pregnant people despite their strong disapproval of abortions.

Evaluations of Past, Current, and Future Efforts in the Fight for RJ.

We all ($n=6$) discussed our reactions to and outlooks on the fight for RJ, half ($n=3$) recalling overwhelming hopelessness after the overturning of *Roe v. Wade* in 2022. Commenting on the first draft of her narrative, Glennon "couldn't will [her]self to put a positive spin or find the silver lining." Further, some of us ($n=3$) noted a fear that the advocacy in which we partook was ineffective in the overall landscape of RJ. Ruth felt she was "constantly in battle, not knowing if and when there will be an end." Despite this doubt and hopelessness, those who felt hopeful in their work ($n=3$) used hope as a sustaining force that kept them motivated to continue the fight. Angela described hope that her RJ advocacy efforts were not in vain:

Though I won't ever know if that moved the person to social action and critical reflection, I have hope that it does! Because my approach to advocacy, especially reproductive justice advocacy, is like planting seeds, I have to hope that that seed will sprout ... I don't lose hope. To be frank, I can't. I don't have the privilege to lose it.

RJ Advocacy as a Component of my Professional Identity. Most of us ($n=5$) described ways in which RJ advocacy was incorporated into our professional identities. Most ($n=5$) also shared ways in which our personal experiences informed our professional and political interests in RJ. Angela stated "the culmination of [her] experiences and emotional reactions launched [her] to care" about RJ. Ruth described the "rewarding" nature of engaging in scholarship with a RJ aim. Several of us ($n=4$) discussed how RJ showed up in the education and

mentorship we provided. For example, Jessica and Glennon reported taking on the role of “educator” and “supportive source” for friends, peers, or anyone who would listen. Some ($n=2$) explicitly outlined how RJ was relevant to clinical practice. Contemplating how to be a clinician in the aftermath of a traumatic pregnancy loss, Gloria provided:

I also wondered with my supervisor whether I should avoid any clients that might have recently experienced a pregnancy loss. What I learned was that it was impossible to avoid because clients often brought thoughts about their reproductive lives to sessions or found reproduction related to their concerns. They were worried about pregnancy, engaging in sex for the first time or more frequently in ways that warranted discussion of safer sex practices, and the like. Even when working with a client without a uterus this proved true.

Expectations From Family and Community About Reproduction and Parenting. Most of us ($n=5$) discussed the ways in which expectations from family and community about reproduction and parenting shaped our trajectories toward RJ advocacy. Family values were prominent in most narratives ($n=5$), with most ($n=4$) describing views that were limiting or harmful. Mary stated, “I can hear the scorn in my mother’s voice if I were to introduce her to the idea of ‘reproductive justice.’” Half of us ($n=3$) stated that education was promoted as a “necessity” facilitating “independence.” Ruth explicitly stated, “Choosing education over children was never an actual choice; it was a must.” Beyond stated values, some ($n=3$) received implicit expectations through modeling. For example, Angela watched her “working mother” come home to do more labor and Glennon observed her mother “economically struggling” to care for multiple children. Despite these challenges, we ($n=3$) felt the pressure to become mothers. However, Angela, pointed out the inherent conflict in these expectations to mother and be educated:

Though I wanted to have children and balance a career, my desire was railroaded by messages that I couldn’t have both. I got these from society and people that I came to know. Older Black people—my maternal grandmother, family members,

friends of family, professionals—that implicitly communicated this was not possible for me, urging me to focus on my education and career and leave boys alone and that my family will come later.

Advocacy as Overwhelming and Exhausting. Despite the communicated importance of RJ advocacy, we experienced a high level of burnout and compassion fatigue. This was demonstrated as most of us ($n=5$) described ways in which our RJ advocacy work felt “overwhelming” and “exhausting.” Many of us ($n=4$) noted having experienced an array of negative emotional responses as it related to RJ advocacy. For example, Ruth stated feeling like she was “constantly in a state of rage” when engaging in RJ advocacy. Likewise, Gloria expressed being “not as happy as [she] was in [her] earlier life” in part due to attacks on reproductive freedom. Both Jessica and Angela also expressed feelings of “disappointment” in others’ response to their involvement in RJ advocacy and recent changes in reproductive rights. Furthermore, two of us commented on the importance of caring for ourselves in order to sustain ourselves in RJ advocacy, but also acknowledged their inability to engage in such self-care. Reflecting on her struggles with self-care, Ruth voiced:

I have found that work to be tiring though and need to refresh and recoup in many ways. I am still not sure what exactly works because I do not feel refreshed, and I do not feel that the fight is done. I am hoping that at some point there is time to rest, but how do you rest when your rights are literally riding on this?

Fears of Inadequacy as a RJ Advocate. More than half of us ($n =4$) communicated a sense of incompetence as an advocate of RJ. For example, Mary described feeling “inadequate as an advocate” and mentioned feeling “limited when [she] compares [herself] to those around [her].” One participant, Gloria, expressed positive support for her colleague’s RJ advocacy work and accomplishments, yet she conveyed a need for higher expectations for herself and required perfection within her RJ advocacy. Despite her identity as a sex-positive psychologist and educator, Gloria critiqued her experiences and abilities to fully engage

in RJ advocacy and noted, “I don’t give myself as much compassion as I offer to students.” She also added that she “still feels something akin to impostorism.” Finally, many of us ($n=4$) expressed concerns regarding the limited impact of their RJ advocacy. Jessica questioned whether “what [she] was doing is enough” and if “there is more [she] can be doing.” Sharing this sentiment, Angela disclosed:

Though I believe the work I do is valuable, I am not sure if it makes the impact I want. There are psychologists and activists that are doing bomb work, and I feel that I am just a little fish. I wonder if my feelings emerge from imposter phenomenon and beginning work as an emerging professional.

Integration

The concept map in **Figure 1** demonstrates the relation of the domains to one another. We described our experiences in youth and over the course of our lives that shaped our conceptualizations of our reproductive lives. These conceptualizations colored personal experiences as people with uteruses that informed our development as RJ advocates. For example, personal reproductive experiences that were disempowering spurred us to action but also often manifested again in our academic careers. Privileges that facilitated the unlearning of early harmful messages about reproduction facilitated the development of an advocate identity; however, structural racism and White supremacy were noted as obstacles to feeling agentic personally or as an advocate. Importantly, the sociopolitical climate, related to reproduction and other identities we held (e.g., gender, race), influenced every other domain. Given the confluence of attacks on reproductive rights, the implications of these attacks on our lives, and our RJ advocacy, we described feeling overwhelmed and exhausted. We evaluated our advocacy efforts in the context of the current state of reproductive rights and often found our work inadequate though we acknowledged the need for self-compassion. Solidarity and community with other RJ advocates served as support in the face of these challenges.

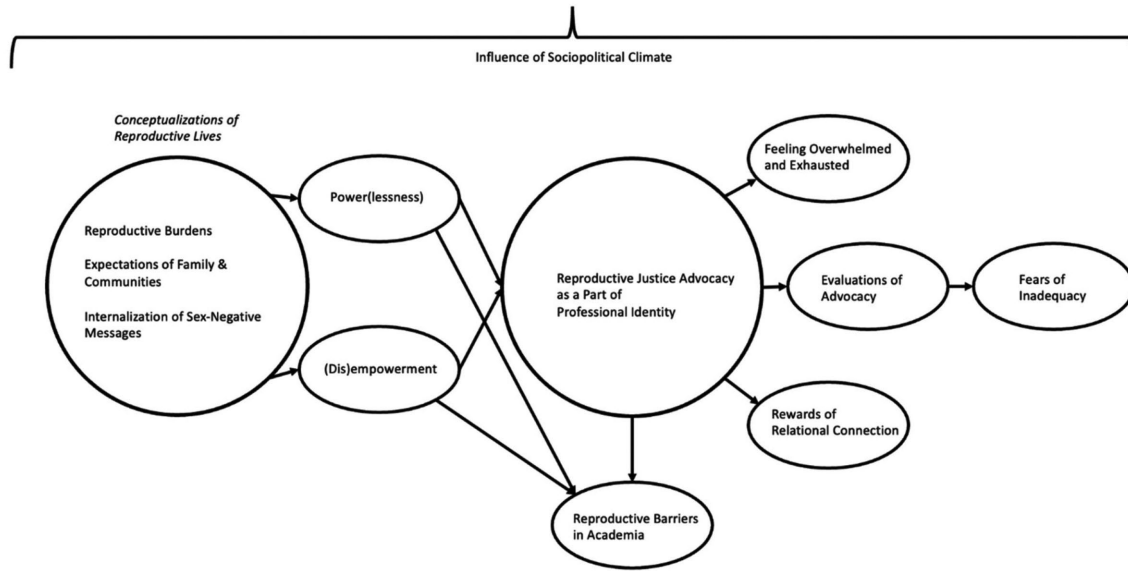


Figure 1. Concept Map of Domains.

Discussion

Using a critical feminist collaborative autoethnographic approach, this study explored the intersection of professional work and the fight for RJ among HSPs and HSPs-in-training with uteruses. Findings suggest that the interplay of personal, professional, and political RJ values took a toll on us and that the most common way of sustaining our efforts was through connection and community with others. The findings also point to the ways in which reproduction-related formal and informal education was often limited and/or sex-negative in youth. Though higher education in some ways facilitated our growth as RJ advocates, it also presented unique barriers rooted in systemic reproductive injustice. Further, contemporaneous and regressive nationwide assaults on RJ represent significant stressors for HSP’s and trainee’s personal, professional, and political lives.

Integration With Previous Literature

Our findings complemented prior literature on a range of topics, including the state of advocacy training in doctoral psychology programs

and burnout among mental health professionals and advocates. Also of note, our findings offer new perspectives to the literature wherein HSPs and trainees with uteruses often find themselves in a “double bind.” RJ advocacy is viewed as a central component of their professional identity and imperative for own and others’ reproductive lives; but, they also recognize the importance of rest and nurturing their own wellness and doing so may feel like an abandonment of their responsibility to advance RJ.

These double-bind experiences are further amplified by interlocking structural forces uniquely shaping challenges for RJ advocates in HSP, often resulting in stratified experiences of reproductive injustices. Notably, our findings point to the healing power of connection amongst advocates, inviting vulnerability and deepening the ability to advocate.

Advocacy and Sexual and Reproductive Health Training. In alignment with previous scholarship, we noted a lack of adequate and quality training in both advocacy and sexual and reproductive health in our training programs (see Abbott et al., 2022; Alexander & Allo, 2021; Mollen et al., 2020). Further, we sought out advocacy experiences unique to RJ advocacy, despite the personal costs and risks of this additional work (see Singh et al., 2010). Though we are unable to draw conclusions about the causal relationship between this lack of training and negative outcomes, it is entirely plausible that this under-preparedness around sexual and reproductive health left some of us vulnerable to burnout, exhaustion, and hopelessness.

Advocacy Burnout. We described several components of burnout including exhaustion, lowered self-efficacy, and hopelessness (see Clark et al., 2009; Killian, 2008; Stebnicki, 2007). We described the relationship between this burnout and our work with clients and general sense of well-being, well-established connections demonstrated in prior studies of burnout among mental health practitioners and HSPs (Bearse et al., 2013; Puig et al., 2012). Our findings also suggest that there may be a unique experience for people with uteruses advocating for RJ that parallels the experience of people of color fighting for racial justice (Danquah et al., 2021). Namely, the

combined effects of working against reproductive injustice while feeling the daily impact of such injustice on their own reproductive lives created a sense of urgency but was also tiring and demoralizing for people with uteruses. Notably, given the unique sociopolitical climate in the wake of the *Dobbs v. Jackson Women's Health* decision and related legislation restricting reproductive rights across the U.S., the fight for RJ became visceral for all of us, but catalyzed a novel sense of disenfranchisement among our White authors. In particular, the role of HSP may exacerbate this dilemma as HSPs work directly with the public, many of whom are similarly impacted by reproductive injustice, leaving little room for them to process their own grief. Importantly, being in connection with others, particularly colleagues, was sustaining for our participants. Likewise, other studies of burnout have identified the support of colleagues and strong work relationships as protective against burnout (O'Connor et al., 2018).

Practice and Advocacy Implications

A sense of community and solidarity was a clear mechanism by which we sustained ourselves in the fight for RJ. Therefore, organizations and training programs, including supervisors and faculty members, could support their colleagues by making their support for RJ and related action visible. Similar to other forms of advocacy in which increased risks were acknowledged for activists early in their careers (e.g., pretenure faculty) and/or with marginalized social locations (e.g., minoritized racial identity; Quaye et al., 2017), we also sometimes expressed a fear of retaliation for their RJ advocacy, especially in academia. Thus, such visibility would invite and model participation in RJ advocacy and facilitate connection with like-minded colleagues. Relatedly, RJ advocates, especially those in positions of power, can engage in civil disobedience in alignment with our ethical principles and goal of transformative change (Flynn et al., 2021). For example, if practicing in a jurisdiction that mandates the reporting of abortions, an HSP may defy such legislation and/or train others as to how to draw upon their professional identity, ethics, and social locations to make determinations about how and when to engage in similar

civil disobedience in the interest of RJ. This action is supported by APA's (2023c) resolution affirming the centrality of confidentiality as it relates to reproductive health and the practice of psychology. Additionally, HSPs could coalesce with other health professionals and RJ-oriented organizations to combat reproductive injustice (Grzanka & Frantell, 2017). Importantly, this desire for an RJ-minded community is likely most generalizable to other HSPs and trainees with an existing commitment to RJ. However, aspirationally, such solidarity would result in growth in the number of HSPs and trainees dedicated to the promotion of RJ. People have sexual rights to bodily autonomy and medically and scientifically accurate sexual and reproductive health information (World Association for Sexual Health, 2014). Among HSPs and trainees who support forced birth and oppose abortions, framing RJ as an ethical imperative can provide critical opportunities for education related to how they may put aside their personal values in order to competently serve clients considering or seeking abortion services. Relatedly, HSPs in training are encouraged to approach faculty through collaborative dialog on integrating reproductive health information in their training. However, as researcher participants noted fear of retaliation through poor evaluations from unsupportive faculty, it is imperative faculty remain reflective of their personal values in order to appropriately evaluate students based on their work.

RJ, as demonstrated in our narratives, is therapeutically relevant, and, thus, must be integrated into clinical practice. It is vital that conversations of reproductive health and related information are normalized wherein practitioners are mindful to avoid stigmatizing language. Additionally, it is imperative that practitioners intentionally create interventions that empower clients. Grzanka and Frantell (2017) suggested narrative therapy interventions were a cogent approach to integrating RJ allowing clients to share and re-author their stories of disempowerment. For trainees with uteruses, in particular, relational cultural therapy could be a helpful framework from which clinicians can use themselves as a therapeutic tool and remain in connection with clients that share stories of reproductive injustice (Jordan, 2017).

Given contemporaneous reproductive injustices that are intersecting in nature, HSP training programs and agencies can improve the quality of training with RJ advocacy by integrating RJ scholarship into their training and offering continuing education to professional HSPs.

The lack of training in sexual and reproductive health, as well as advocacy skills, was discussed in all of our narratives. Thus, HSP training programs could reevaluate the amount and quality of the training they offer to their graduate students as a way of both preparing them for expected clinical work and for the advocacy work in which many HSPs and graduate students engage. APA's benchmark competencies for HSPs make clear that advocacy is an expectation of professional psychologists and training programs must prepare students for this important facet of the occupation. On a larger scale, APA could create accreditation requirements that require psychology training programs to include training specific to both SRH and advocacy, as a means of standardizing the training students can obtain on these topics.

Limitation and Future Directions

Although these few stories offer rich and descriptive data, the voices of many people with uteruses with different genders, sexualities, ability statuses, and racial or ethnic and social class backgrounds are absent. Rooted in intersectionality scholarship (Cole, 2009; Crenshaw, 1989), we encourage multiple methodologies grounded in critical frameworks. These can uncover the nuances of reproductive (in)justice while simultaneously centering stories of strength and advocacy amongst RJ advocacy advocates with uteruses and diverse identities. Relatedly, the homogeneity of the current sample with particular regard to age, as all authors were under 40 and practicing fewer than 12 years, may have influenced the findings. For example, though not specific to advocacy, a meta-analysis of studies of burnout among mental health practitioners found higher age was correlated with more negative attitudes, but also a higher sense of accomplishment (O'Connor et al., 2018). Thus, our sense of ineffectiveness and inadequacy may have been a function of our early career stage. Longitudinal methodologies that employ a multisystemic focus can further our knowledge of the relationship between RJ advocacy and well-being across the lifespan of HSPs with uteruses.

Five of the six of us were also childfree by choice at the current stage of our lives, though some desired children in their futures. Thus, although all authors were engaged in thought about future family planning, only one of us was able to speak to lived experiences of

parenthood as an element of their work as an RJ advocate. Future studies of RJ advocacy may benefit from centering the experiences of HSPs who are parents with uteruses. Further, as our sample does not reflect all HSPs and trainees, future studies may benefit from exploring attitudes about RJ as an ethical imperative among HSPs and trainees who are less active in and/or personally affected by RJ advocacy.

Conclusion

Congruent with our feminist, collaborative autoethnography approach, we desired to offer data rooted in our lived experiences and embodied knowledge to benefit our health service psychology community. Our findings suggest obstacles in academia for people with uteruses replicate other reproductive injustices in HSP's and trainee's lives and simultaneously catalyze and inhibit RJ advocacy. Connection and solidarity with like-minded colleagues may be a particular source of strength for HSPs and trainees in the face of oppressive and restrictive attacks on our collective and individual reproductive freedom.

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Appendix

Research Questions and Writing Prompts

1. How, if at all, do our personal reproductive lives and professional reproductive justice advocacy influence one another?
 - (a) Chronologically, beginning in youth, outline how your orientation to reproductive justice has developed over time.
 - (b) How, if at all, do socialization scripts and contextual factors (e.g., identities, group memberships, value systems) play a role in your views and work within reproductive justice?
 - (c) In your various roles (e.g., educator, researcher, clinician, partner, friend, family member), what form, if any, does reproductive justice advocacy take? How is it received by others?
 - (d) How, if at all, do your and other's intersecting power and identities shape the attacks on reproductive rights?
 - (e) What, if any, reproductive choices/sacrifices/decisions have you had to make while working towards your professional goals in higher education?
 - (f) How, if at all, do ongoing and fluid attacks on reproductive rights (e.g., systemic and interpersonal) interact with your professional identity and

work?

2. How do we sustain ourselves in the fight for reproductive justice?
 - (a) How, if at all, have you navigated being a reproductive justice advocate across your professional experiences? How, if at all, has your relative power in those experiences influenced how you advocated?
 - (b) What, if any, strengths and successes have you experienced in your reproductive justice work?
 - (c) How, if at all, do you care for yourself and stay healthy while doing reproductive justice work?
 - (d) How, if at all, do relationships and communities (e.g., professional, personal) support your reproductive work and advocacy?

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