THE OVERTURN OF ROE V. WADE AND UNANTICIPATED EFFECTS: GIVING WOMEN WITH CHRONIC HEALTH CONDITIONS A VOICE THROUGH LISTENING CIRCLES

by

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ABSTRACT

PAYTON DAVENPORT. The Overturn of Roe V. Wade and Unanticipated Effects: Giving
Women with Chronic Health Conditions a Voice Through Listening Circles.
(Under the direction of DR. VICTORIA C. SCOTT)

Roe v. Wade was overturned on June 24, 2022, ending nationwide abortion rights and changing the abortion landscape all across the United States (Berg & Woods, 2023; Byron et al., 2022). Consequently, the policy change came with numerous unanticipated effects that are impacting the health and well-being of women with chronic health conditions (Heath, 2022; Louise, 2022). However, the effects of the policy change on women with chronic health conditions are not widely known, in part due to the recentness of the overturn and due to the limited research on women of reproductive age with chronic health conditions. Culturally competent and woman-centered interventions, such as listening circles could serve as a method for women with chronic health conditions to share experiences and process events, including the overturn of Roe v. Wade (Boyes-Watson, 2005; Indigenous Education, n.d). The benefits of listening circles are not widely researched, including the method's ability to increase one's sense of psychological empowerment and social connectedness. The current study begins to address the potential benefits of listening circles for women with chronic health conditions as well as understand the unanticipated effects of the overturn by analyzing the dialogue from 33 participants who participated in listening circles. Using a reflexive thematic analysis data analysis method, four overarching themes were generated, including how the policy change has compromised access to reproductive healthcare, caused additional psychological distress, decreased agency, and autonomy, and exacerbated health inequities. When compared, the results from the study's pre and post-test survey data indicated that listening circles do increase one's feeling of psychological empowerment and social connectedness. However, the findings are only generalizable to low-income economically marginalized women who reside in the South Atlantic region of the U.S. Despite limitations, the key implications of these findings add to the growing literature and research on listening circles, filling the gap in research on listening circles as a health intervention while providing crucial information that can impact and shape future research and policy.

Keywords: Roe v. Wade, chronic health conditions, reproductive healthcare, abortions, listening circles

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DEDICATION

I dedicate this thesis to everyone who has supported my educational pursuits and passions. I also honor the feminist scholars who have paved the way for future generations; their wisdom and resilience continue to inspire my work and passion for social justice. Here's to strong women!

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Reproductive and sexual healthcare (RSH) has been widely acknowledged as a basic human right by the United Nations (United Nations Human Rights Office of The High Commissioner, n.d.). The inclusion of abortion access falls under comprehensive RSH; therefore, making it a human right and a critical component of an individual's comprehensive healthcare (Centers for Disease Control and Prevention, n.d.; Tanne, 2022; United Nations Human Rights Office of The High Commissioner, n.d.; Verbeist et al., 2022). Reproductive healthcare helps prevent infection, injury, or long-term health issues thus making this form of care crucial for women 18 - 49 years old (Centers for Disease Control and Prevention, n.d.). However, the effects of trigger laws enacted after the overturning of Roe v. Wade in many U.S. states have caused great concern for the short and long-term health and well-being of women of reproductive age (Gunja et al., 2022; Tanne, 2022).

1.2 The Overturning Of Roe V. Wade

Roe v. Wade was enacted into law in the United States (U.S.) on January 22, 1973. The decision made in the landmark case precluded states in the U.S. from banning abortions before 24 weeks of pregnancy, thus abortions were legalized federally for all individuals (Berg & Woods, 2023; Byron et al., 2022). Before Roe v. Wade, many individuals did not have access to safe abortions so they would take an alternative route of self-induced abortions, such as inserting objects into the cervix or ingesting toxic substances (Grossman et al., 2022). Roe v. Wade provided individuals the ability to receive abortions through a variety of safe routes like using the medications mifepristone and misoprostol in combination or misoprostol alone which provided the opportunity to have a safe and effective early pregnancy termination (Grossman et al., 2022).

However, after 49 years, the case was overturned by the U.S. Supreme Court on June 24, 2022 (Byron et al., 2022). This ruling ended nationwide abortion rights; consequently, state legislatures now determine the legality of abortions (Byron et al., 2022). Before the official ruling, many states had trigger laws which refer to laws that are created by states to go into effect automatically when "triggered" (i.e., if Roe v. Wade is overturned) that would take effect if the case was officially overturned (Byron et al., 2022; Tanne, 2022). With the overturn of Roe v. Wade, several trigger laws went into effect. In many states, these laws impose strict abortion bans. For example, in Tennessee, abortions are inaccessible even in incidents of rape or incest (Byron et al., 2022; Sangtani et al., 2023).

In response to the overturn of Roe v. Wade, President Biden signed two Executive Orders (EO) in July and August 2022. The Executive Orders were directed to the U.S. Secretary of Health and Human Services to enforce protective measures (e.g., expand access to abortion care), and directed toward states to expand Medicaid waivers to help women[1] who are traveling between states to receive abortion procedures (Byron et al., 2022). Despite the series of presidential efforts, these actions may not be sufficient to offset the effects of the overturning (Byron et al., 2022).

1.2.1 Effects Of The Overturning

The overturning of Roe v. Wade is affecting care across the nation, such as limiting access to abortion procedures and treatment options, leading to new challenges for healthcare providers and adverse outcomes for patients (Berg and Woods, 2023; Sangtani et al., 2023). Due

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[1] In this paper, the term "woman" is defined by reproductive anatomy when citing other studies or referring to the individuals in the study. However, I acknowledge that the term is not inclusive, is discriminatory in nature, and people born with ovaries and a uterus who do not fit the binary nature of the term may need reproductive services.

to the effects of new abortion restrictions and bans, many physicians are facing the possibility of lawsuits, being considered felons, or being subject to losing their licensure to practice if they perform abortion procedures or offer treatment, such as prescribing the abortion pill (Tanne, 2022). Many physicians now have to justify performing abortions in the case of a medical emergency, but since the definition of an *emergency* differs by state, the justification may not matter in the face of the law (Tanne, 2022). For instance, many states define a medical emergency as one that may cause death if necessary care is not provided immediately. The distinction of what is an emergency or not will leave many patients (e.g., women with cancer or other health conditions) with the choice to either delay needed treatments (e.g., chemotherapy) or continue with the treatment despite the risks. Delaying medical treatment could worsen the current condition the patient has or result in maternal mortality (Suran, 2022). If a woman decides to proceed with treatment for their health conditions, the teratogens from treatment options, such as chemotherapy, seizures, and migraines, increase the risk of preterm birth, congenital abnormalities, and miscarriage (Rubin, 2022; Suran, 2022). Moreover, depending on a state's level of restriction on abortions, women seeking abortions could face criminal punishment such as felony charges and jail time (Tanne, 2022).

Because many of the restrictions and bans include specific rules and guidelines, abortion procedures, medications, and other treatments are also being modified. For example, hospitals are turning patients away even in the instance of pre-eclampsia, vaginal bleeding, and premature rupture of membranes because the medications and treatments used to assist with these medical problems are also used for abortions (Tanne, 2022). Also, providers in abortion-restricted/prohibited states are now being directed to acknowledge these medications and additional treatments as only assisting in abortions, ignoring the other ways the medication is used (e.g., management and treatment of chronic conditions). Therefore, many women with CHCs who take these medications for primary medication use (management and treatment of chronic conditions) are being turned away or denied treatment (Byron 2022; Heath, 2022; Tanne, 2022). As a result, the overturning has caused unanticipated effects for women with a variety of chronic conditions.

1.3 Unanticipated Effects On Women With Chronic Health Conditions

Chronic health conditions (CHC), also called chronic illnesses or chronic diseases, refer to any of a number of conditions that impacts a person's daily life by limiting their usual activities, requires significant, ongoing medical attention, and lasts longer than one year (March of Dimes, 2019). Common chronic conditions include heart disease, cancer, chronic lung disease, stroke, Alzheimer's disease, hypertension, diabetes, and chronic kidney disease (Centers for Disease Control and Prevention, n.d.). Chronic conditions that are specific to women's reproductive health include endometriosis, Interstitial Cystitis (IC), Polycystic Ovarian Syndrome, and some sexually transmitted diseases such as Herpes simplex virus (HSV). Globally, chronic conditions and non-communicable diseases are the largest causes of death (Centers for Disease Control and Prevention, n.d.). The U.S. has both the highest number of reproductive-age women with multiple chronic conditions (MCC), and the highest maternal and infant morbidity among high-income countries (Gunja et al., 2022). Because of these rates, there is a compounding risk of pregnancy complications for women with MCC in the U.S. since there are high rates but low quality of care (Gunja et al., 2022; Hassan et al., 2023a, 2023b).

1.3.1 Care Challenges For Individuals With Chronic Health Conditions

Living with chronic conditions requires constant lab work, tests, and repeated doctor trips (Miller, 2022). However, women with chronic conditions face more significant challenges because of the long history of undermining women within the U.S. healthcare system (e.g., perceiving them as less than others due to their chronic conditions, and not believing them due to biases based on sexism and ableism) (Verbiest et al., 2022). In addition to delayed or lack of diagnosis, a recent national survey, the Remedy Health Survey, found that one in ten women report they lack comfort with their provider, therefore, preventing them from sharing the details of their symptoms or how they are managing their condition (Miller, 2022). Additionally, one in five individuals reported they do not trust the healthcare system due to being hurt or disrespected by doctors. Due to traditional medical models and teachings being based on standards set by males, physicians, oftentimes more males than females, evaluate female patients as hysterical or dramatic when a patient is emotional about their health concerns (Miller, 2022; Werner and Malterud, 2003). Consequently, this has resulted in many providers not believing their patients when they present them with their concerns (Miller, 2022; Werner and Malterud, 2003). However, being dismissed by a provider can cause a patient to become more upset, lead to a level of distrust with their provider, and form the belief that they are being perceived as overly emotional and lying. Additionally, this type of treatment has resulted in incidents of delayed treatment, misdiagnosis of conditions, or the cancelation of appointments (Hassan et al., 2023a; Miller, 2022). Given the larger context of women not trusting healthcare professionals, the overturning of Roe v. Wade — preventing women from accessing necessary, equitable care — can exacerbate the feeling of mistrust of the larger healthcare system; therefore, amplifying the challenges that patients with chronic conditions experience, particularly pregnant women.

1.3.2 Pregnancy for Women With Chronic Health Conditions

Pregnancy for women with chronic conditions is complex because pregnancy can worsen underlying conditions and compromise an individual's health or even cause death, thus abortion services are especially key to the sexual and reproductive healthcare accessed by women with chronic conditions (Lassi et al., 2014). Due to these risks, many women with chronic conditions take additional steps to prevent pregnancy. Often, one of these steps includes receiving abortions (Hassan et al., 2023a). Without abortions, women with chronic condition treatment and medication management may be asked to change or stop their current treatment due to the teratogenic effect of these treatments that could cause fetal malformation or possible miscarriages (Hassan et al., 2023a). In the U.S., females are twice as likely to be diagnosed with autoimmune disorders (e.g., lupus and rheumatoid arthritis), and one in 16 patients use teratogen-labeled medication. If these patients have unplanned or unintended pregnancies, they often choose to have abortions due to the extreme consequences for both the fetus and the mother caused by their medications (Hassan et al., 2023a; Rubin, 2022). For example, past research findings on individuals enrolled in the iPLEDGE REMS, a program aiming to minimize fetal exposure from isotretinoin teratogenicity, found out of 2720 pregnancies documented, 46% resulted in elective termination (iPLEDGE, n.d.; Winterstein et al., 2024). However, with Roe v. Wade being overturned, many of these women no longer have access or opportunity to have abortions (Byron et al., 2022). Some providers are now asking these pregnant women with chronic conditions to replace their current medication with alternative, less-tested medications, resulting in reduced treatment effectiveness (Hassan et al., 2023a).

Although pregnancy for many women with chronic conditions is uncertain, some women with chronic conditions choose to go forth with pregnancy. However, these women are frequently met with poor-quality reproductive care due to larger societal beliefs that women with chronic conditions are not sexually active and do not want to or cannot have children (Hassan et al., 2023a, 2023b). These societal beliefs also portray these women's bodies as valueless resulting in society pathologizing these individuals as less than (Hassan et al., 2023b). This has led some providers to provide disproportionate, poor-quality reproductive care to these women due to the belief that if the body is not of *value* then it cannot carry a child to term (Hassan et al., 2023b). For example, women with chronic conditions regularly need subspecialists to provide additional clinical expertise during pregnancy, yet a significant number of specialists do not have the basic knowledge, skills, or resources for reproductive and sexual health disease management, or they are uncomfortable addressing pregnancy options and choices (Attanasio, 2022; Talabi et al., 2022).

Provider knowledge and bias can also result in conflicting and inaccurate advice about topics, such as medication safety during pregnancy (Attanasio et al., 2022; Talabi et al., 2022). This can be dangerous due to the risks associated with certain chronic conditions during pregnancy. For example, conflicting or inaccurate care for women with Type 1 & 2 diabetes could result in congenital malformations, preterm delivery, or perinatal mortality of offspring. These effects can also be seen in women with non-gynecological chronic conditions who often do not receive appropriate reproductive care or services that could be beneficial, such as lipid testing, diet, and weight management (Steel et al., 2015). With the overturning of Roe v. Wade, the effects of disproportionate rates of poor-quality care brought upon by larger societal beliefs and preconceptions are likely to increase because more women with chronic conditions will be forced to continue their pregnancies putting their body and their fetus at risk.

The risk and consequences associated with pregnancy only worsen for women as they age (i.e., increased risk of fetal death, stillbirth, and ectopic pregnancies) (Berg & Woods, 2023). Examples of chronic conditions associated with aging are autoimmune diseases (e.g., inflammatory bowel disease and multiple sclerosis), conditions that affect the heart (e.g., heart disease), and conditions that affect hormones (e.g., diabetes) (Berg & Woods, 2023). Additionally, 51% of midlife women (ages 40-65) have unintended or unplanned pregnancies because their reproductive care needs (i.e., contraception) go unaddressed due to their age (Berg & Woods 2023).

1.4 Anticipated Long-Term Effects Of Policy Overturned For Women With Chronic Health Conditions

Now that Roe v. Wade has been overturned, there is concern about the significant long-term health effects on healthcare practices; specifically, for women with chronic conditions. For example, a major concern pertains to pregnancy complications and limited access to needed medications because of new medication restrictions (Louise, 2022). Additionally, medical professionals and researchers are concerned for the mental health of individuals if they are denied access to safe abortions and additional treatments.

1.4.1 Pregnancy Complications And Medication

With Roe v. Wade being overturned, Berg and Woods (2023) noted that clinicians' medical training on and experience with how to manage pregnancy complications such as infection, ectopic pregnancies, placental abruption, and eclampsia will likely decrease because treatment for these complications often involves medications that assist in abortions. This is proposed to increase health complications for specific populations of individuals who are at higher risk of pregnancy and other reproductive health complications such as women with chronic conditions (Berg & Woods, 2023; Miller, 2022).

In addition, clinicians are starting to restrict certain prescription drugs (e.g., methotrexate and misoprostol) that are used daily to treat and manage chronic conditions such as Crohn's Disease, Lupus, and certain cancers (Suran, 2022). Pharmacies in states with more strict abortion bands are also restricting the distribution of these medications, even if prescribed by a medical provider (Heath, 2022).

Prescription restrictions can change the condition management for many individuals with chronic conditions which will lead to longer, negative health effects because new treatment may not be as effective or accessible (Heath, 2022; Louise, 2022). Furthermore, despite analysis of prescription drug claims, researchers have indicated that these new drug restrictions disproportionately impact women who are not pregnant (71% of people using methotrexate are women). Meaning, that women with chronic conditions who do not need or want abortions (i.e., are solely using the medication to manage their chronic conditions) will face medication restrictions since they are women. This type of restriction could be considered discrimination based on age, sex, and disability which could violate Section 1557 of the Affordable Care Act (Heath, 2022).

1.4.2 Mental Health

Women with chronic conditions face greater mental health stressors due to the prevalence of living with life-altering conditions, such as functional deterioration, social isolation, anxiety about their future, health, guilt, and low self-esteem (Herrara et al., 2021). These stressors increase their risk for comorbidities such as depression which, in turn, may decrease chronic condition intervention efficiency, worsen overall well-being, and worsen long-term prognosis (Herrara et al., 2021). Women denied access to abortions experience higher levels of anxiety, lower life satisfaction, and lower self-esteem compared to those not denied access (Miller, 2022). With the overturning making abortion access uncertain, there is a significant concern for the mental health of women with chronic conditions who are denied abortions. Identifying ways to empower women to have agency over their health in light of the overturning of Roe v. Wade can help promote women's health and well-being.

1.4.3 Empowerment And Autonomy

Empowerment Theory. Empowerment refers to a process in which people, organizations, and communities obtain a level of proficiency over the circumstances presented to them (Rappaport, 1987). On the individual level, empowerment is referred to as psychological empowerment which is understood as the beliefs of one's level of competence, ability to exert control, and ability to understand the socio-political environments around them (Zimmerman, 2012). Empowerment is not just an individual's orientation, it is a theoretical framework that helps explain the processes and ramifications of efforts used to control and exert power over decisions on three different levels: individual, organizational, and community levels (Rappaport, 1995).

Empowerment theory is broken down into two parts: process and outcomes (Zimmerman, 2012). The *process* is the attempt to gain control, access resources, and critically understand a person's social environment (can be done through participating in different actions, programs, and interventions) while the *outcomes* are the effects of the interventions (the process) designed to empower them (Zimmerman, 2012). Empowerment theory suggests that both the process and outcomes are empowering; meaning the process is empowering by itself while the outcomes can also lead to empowerment. However, empowerment is complex and varies in the outward form. There is no formal standard that can fully capture its meaning due to the complexity of individuals. The behaviors of each individual vary depending on personal characteristics and context, meaning, the behaviors necessary for a 10-year-old to be empowered are different than those of a 30-year-old woman with multiple chronic conditions. This suggests empowerment takes on different forms in different contexts (Zimmerman, 2012).

On the individual level, empowerment is referred to as psychological empowerment, defined by Zimmerman (2012) as the “beliefs about one's competence, efforts to exert control, and an understanding of socio-political environments.” Individuals who experience psychological empowerment can identify those with power, identify resources, identify their connection to the issue of concern, and identify factors that influence their decision-making. This process is called *understanding causal agents* which is an analytical skill often gained through participation in activities and organizations (Zimmerman, 2012).

Autonomy. A woman's right to choose to have an abortion or make any decision regarding their body is an important factor in their level of empowerment (Nieuwenhuijze & Leahy-Warren, 2019). However, empowerment is impacted by the external, socio-political, and environmental context a woman is placed in when making their choices and decisions. Meaning, if women are in a position where individuals do not recognize a woman's autonomy and equality to make their choices, then women's empowerment overall is threatened (Nieuwenhuijze & Leahy-Warren, 2019). With the overturning of Roe v. Wade, the lack of reproductive autonomy and choice women with chronic conditions have is now at a greater risk thus further decreasing their empowerment. However, the phenomenon of limiting a woman with chronic conditions' power of choice is not a new concept. The U.S. has a long history of undermining the reproductive autonomy of individuals with chronic conditions and disabilities. Specifically, reproductive autonomy has rarely been a priority in the laws, healthcare, and clinical practice for those with chronic conditions (Hassan et al., 2023b). This can be understood when considering the eugenics movement which was associated with forced sterilizations of those with disabilities and chronic conditions (Hassan et al., 2023b). Current biases and perceptions already impact healthcare access and quality for these individuals (Hassan et al., 2023b). Having abortion access gives these individuals a greater sense of choice over their healthcare, and gives them more power to not allow their health condition to control them. However, with the overturning, this choice is becoming more limited, and more women with chronic conditions will likely be forced to continue their pregnancy despite the risk (Hassan et al., 2023). The loss of bodily autonomy for women with chronic conditions is more likely to be seen in states with the strictest abortion bans, laws, and restrictions which are also the states with the largest number of individuals with chronic conditions (Hassan et al., 2023a), thus increasing the chance of loss of bodily autonomy, choice, and empowerment (Beck et al., 2024; Nieuwenhuijze & Leahy-Warren, 2019). Greater empowerment during pregnancy is associated with improved health and well-being, but if a woman begins their pregnancy with their empowerment compromised because they were not given a choice, then this poses health concerns for these specific individuals (Nieuwenhuijze & Leahy-Warren, 2019).

1.5 Women-Centered Interventions

There is a growing amount of research that emphasizes the importance of *listening* when implementing interventions for women (Talabi et al., 2022). This emphasis stems from the long history of injustice enacted on women which is why researchers such as Talabi et al. (2022) have noted the need to move towards uplifting lived experiences and giving a voice to those who are shut down and not included in research. By shifting the focus of research to center on engaging the participant, more research is capable of being applied to specific target populations such as women with chronic conditions (Verbiest et al., 2022). An example of this type of research focused on understanding the experiences of Black and Native American women with chronic conditions; specifically, their experiences accessing and receiving reproductive healthcare. The framework of the study was based on the value of person-centered research through the use of focus groups which emphasizes the participant's voices while allowing the researchers to listen and practice empathy (Verbiest et al., 2022). Although the researchers understood the experiences of Black and Native American women in the reproductive health setting, using the focus groups, Verbiest et al. (2022) were able to receive participant feedback that provided further confirmation and clarification of old and new ideas developed. The women who participated described the focus groups as being meaningful, bringing a sense of community, and promoting healing that then made them want to help women like themselves (Verbiest et al., 2022).

While giving a voice to those marginalized from research is important, it is also essential to understand societal factors and other unique life circumstances impacting these individuals. Many interventions, prevention initiatives, and programs are not structured to consider societal factors and individual differences; therefore, making them a “one-size-fits-all” and inapplicable to different populations such as women with chronic conditions (Schumacher, 2014; Ziabakhsh et al., 2016). Schumacher (2014) and Ziabakhsh et al. (2016) suggest shifting research to support gender-specific interventions (i.e., women-centered) because this perspective considers individual differences. When applying a woman-centered intervention, context is an essential element. This means understanding women's unique life circumstances and applying them to aspects of the intervention or study, such as the structure and setting, allowing the intervention to be more applicable and useful (Schumacher, 2014; Ziabakhsh et al., 2016). A group-based and women-centered intervention referred to as listening circle (LC) has been described as fostering sisterhood and closeness because they create a safe environment allowing authentic communication, open disclosure, and support (Schumacher, 2014 & Ziabakhsh et al., 2016).

1.6 Listening Circles

Listening circles, commonly called sharing or talking circles, draw on an Indigenous circle practice known as healing circles that are rooted in traditional Indigenous culture. Healing circles were used for constructing collective decisions, passing down values and culture, sustaining the community, and restoring harmony (Boyes-Watson, 2005; Indigenous Education, n.d). The healing circle's structure is based on the indigenous medicine wheel that represents the interconnectedness of life and equal participation (Abbott et al., 2022). As the circles are constantly flowing, like medicine wheels, there are no beginnings and there is no one person in a position of power, promoting open and honest conversation (Latimer et al., 2018).

A LC is composed of typically 30 or fewer individuals (W.K. Kellogg Foundation, 2017). Once gathered in a circle, the process starts with a brief opening about the circle's purpose and then transitions into the listing of ground rules (i.e., nobody is allowed to speak while the other has the talking piece). The circle ends with a final statement about the talking piece/object (chosen by the facilitator and usually carries a significant meaning relevant to the circle participants) that is then passed to the person to the left (the circle always flows in a counter-clockwise motion) (Mehl-Madrona & Mainguy, 2014; W.K. Kellogg Foundation, 2018). The process repeats until each person has had the chance to speak (Mehl-Madrona & Mainguy, 2014). However, LCs, unlike healing circles, are not facilitated in the First Nations contexts, which often include additional cultural protocols such as a talking piece (Indigenous Education, n.d.).

The popularity of the LC is growing due to the circle structure because it prevents reactive communication and instead fosters reflection and deep listening (Mehl-Madrona & Mainguy, 2014). If participants react with comments outside of their turn, then the facilitator stops the circle, reminds them of the rules, and allows the individual whose turn it is to continue talking (Mehl-Madrona & Mainguy, 2014). The techniques and structure of LCs foster respect, model good listening skills, settle disputes, resolve conflicts, and build self-esteem (Mehl-Madrona & Mainguy, 2014; Parker et al., 2021). As a psychological technique, it allows individuals to feel a cathartic relief from the release of sharing problems or concerns because the structure encourages self-exploration with empathy and support (Mehl-Madrona & Mainguy, 2014).

More recently LCs have been used in research, health promotion, and the teaching of culture and traditions (Latimer et al., 2018). Specifically, researchers have used LCs to assist in the discussion and understanding of sensitive and personally lived experiences (Abbott et al., 2022). The W.K. Kellogg Foundation (2018) has used LCs to stimulate intentional conversations, open consciousness, and give voice to those whose stories go untold. The result of these circles motivates participants to take action for change (Dohrn et al., 2022; W.K. Kellogg Foundation, 2018).

1.6.1 Benefits Of Listening Circles

Financial. LCs are continuously highlighted in research as a useful tool and intervention because of the benefit of them being low-cost (Wilken & Nunn, 2017). For example, LCs have the potential to drastically decrease the economic costs of healthcare while simultaneously improving an individual's quality of life (Mehl-Madrona & Mainguy, 2014; Wilken & Nunn, 2017). Instead of relying on a professional's expertise, LCs allow participants to help one another through the sharing of stories, experiences, and advice (Mehl-Madrona & Mainguy, 2014). Having a safe space to discuss sensitive and personal topics may help decrease visits to hospitals, clinics, emergency rooms, and specialty doctors thus decreasing spending on healthcare costs which are considerably higher for individuals with chronic conditions because of their need for more medications, treatments, and care visits (Miller, 2022).

Psychological Empowerment. Empowerment theory considers the individual level of empowerment as “psychological empowerment”. Specific participatory activities such as LCs promote psychological empowerment because they allow individuals to understand and identify the key components that make up psychological empowerment (i.e., identify those in power, and identify resources). For example, LCs allow participants to share different narratives. The sharing of narratives is labeled as a resource because it gives those with a lack of social, political, or economic power a voice to create their narrative while also adding to the collective narrative of specific groups (women with chronic conditions) (Rappaport, 1995). Because LCs allow participants to identify the resources of personal and collective narratives, the circle's help increase participants' psychological empowerment. In previous research addressing the nursing experience during COVID-19, “circles of care” were adapted as a form of LC. The study's participants, nurses, shared their own experiences while also forming a collective narrative of how they were feeling as a whole (Dogn et al., 2022). Many participants reported that the circles brought them hope for change because they were able to share their experiences, create their narratives, and then come together to form a collective narrative as a group with shared experiences (Dogn et al., 2022). Participants were able to identify resources of narratives while participating in the circles of care; they then demonstrated characteristics of being psychologically empowered.

For women with chronic conditions, their voices are often quieted and the narrative is written for them by people in power (Shelton et al., 2022). LCs prioritize the voices of the participants while encouraging others to envision the life of the other's perspective while also respecting and acknowledging it whether they agree or not (Parker & Bickmore, 2020). Using LCs, women with chronic conditions can change the pre-existing narrative chosen and forced on them, and change the narrative of the collective group participating, inevitably, increasing their psychological empowerment.

Social Connectedness. Social connectedness is defined as the "internal sense of belonging and is defined as the subjective awareness of being in a close relationship with the social world. The experience of interpersonal closeness in the social world includes proximal and distal relationships with family, friends, peers, acquaintances, strangers, community, and society. It is the aggregate of all these social experiences that are gradually internalized by the individual…" (Lee & Robbins, 1998, p. 338). Individuals with high levels of social connectedness are better able to manage their own needs and emotions which makes them less prone to low self-esteem, anxiety, and depression which are common among individuals with chronic conditions (Herrara et al., 2021). Additionally, connections are an essential need for humans; specifically, women. Having and sustaining relationships and connections are essential for individuals to flourish in all dimensions of wellness (Schumacher, 2014). LCs are a useful intervention that allows individuals to share authentic narratives among a diverse group of peers, therefore, enhancing the perceptions of human interconnectedness (Christopher, 2018). Circles allow for basic human connection through eye contact, proximity to others, and experiences of belonging (Christopher, 2018). Because the structure of LCs creates a safe space for open and honest dialogue reciprocated with respect and empathy, individuals feel connected and respected by others (W.K. Kellogg Foundation, 2018). Safe spaces also help individuals overcome any communication barriers that could hinder connectedness among a group because they encourage both the acts of giving and receiving support from one another (Hodge et al., 1996). Actions of continuous giving and receiving, increase a person's perception of emotional support from their peers (Hodge et al., 1996; Mehl-Madrona & Mainguy, 2014). Moreover, LCs help increase the level of interpersonal trust which may lead to participants feeling more motivated to take advantage of social opportunities which can strengthen connectedness (Lee & Robbins, 1998).

Social Justice. Moreover, LCs create a space for social justice to manifest because they give suppressed voices a platform to share their narrative or stories (Brown & Lalla, 2020). Also, LCs force evaluators and/or researchers to be silent thus forcing them to be fully focused on the conversation between the participants, and allowing them to practice listening skills to help them develop strong interpersonal relationships with the participants. Instead of the researcher being the focus of an intervention, LCs are fully directed by the conversation and narratives of the participants, thus diminishing any power the researcher may hold over the participants (Rappaort, 1995). Due to this change in the researcher and participant dynamic, the playing field is evened out and the researcher goes from the expert to a possible change agent, collaborator, and critical friend (Brown & Lalla, 2020). This allows for introspection from both the researcher and participants to understand their own biases and then reflect on them (Brown & Lalla, 2020).

1.7 Need For Research On The Experiences Of Reproductive-Age Women With Chronic Conditions

There is limited research and data on women of reproductive age with chronic conditions; specifically, research that focuses on improving reproductive health care for women with chronic conditions (Miller, 2022; Verbiest et al., 2022). With the overturning of Roe v.

Wade, equitable access to reproductive care such as abortions is uncertain; therefore, proposing a threat to women's bodily autonomy and empowerment. Due to the effects of the recent policy change and limited research, there is a need for mixed-methods research that captures these individuals' lived experiences by having meaningful and impactful conversations that can then help inform interventions and solutions and fill research gaps (Talabi et al., 2022).

1.8 Reproductive Justice

Due to the compounding issues of ableism, sexism, and ageism, the overturning of Roe v. Wade has produced unanticipated challenges for women with chronic conditions (Hassan et al., 2023a, 2023b). For these women, the overturning can potentially worsen their health and well-being (Hassan et al., 2023a, 2023b; Hyatt et al., 2022). Reproductive justice (i.e., the right to maintain autonomy while also having the decision to have children or not have children, and parent children in a sustainable and safe community) is essential for all women; specifically, those whose voices were already silenced before the overturning (Hassan et al., 2023b; Hyatt et al., 2022). Prioritizing research that aims at understanding the lived experiences of women with chronic conditions in a post-Roe v. Wade world will help us understand how policy changes (Roe v. Wade being overturned) can exacerbate health inequities (Hassan et al., 2023b).

The use of a design that uses qualitative and quantitative methods, a woman-centered intervention, and LCs, will help fill gaps in research while giving women with chronic conditions a space to share their lived experiences.

1.9 Current Study

The present study is guided by the following research questions:

RQ #1: How effective are listening circles in promoting social connectedness and psychological empowerment for women with chronic health conditions?

RQ #2: How has the overturning of Roe v. Wade impacted the health and well-being of women with chronic health conditions?

This study aims to fill two major gaps in research that were previously addressed in the literature review summarized above:

1) Listening Circles are increasing in use as a method for discussing sensitive and personal experiences, and have been noted to increase social connectedness and leave participants feeling more psychologically empowered. However, there are limited research findings that focus on if the intervention significantly increases one's feelings of these two emotions after participating in the circle. The study aimed to understand the effectiveness of listening circles in eliciting these two feelings.
2) The overturning of Roe v. Wade came with numerous potential unanticipated effects including impacting the health and well-being of women with chronic conditions. Due to the United States' healthcare system's long history of undermining these individuals, their voices are often silenced which has had negative effects on their access to equitable care as well as having full bodily autonomy. However, there is limited research on the direct and indirect impacts of this policy change on this population's health and well-being. This study aimed to increase the visibility of these larger issues by giving these women a place to share their experiences and have a voice.

CHAPTER 2: POSITIONALITY STATEMENT

I consider myself an intersectional feminist, and I am not afraid to admit it despite the negative connotation attached to the word “feminist”. If you had asked me in 2018 if I considered myself a feminist, I probably would have hesitated to answer because so many people believe that if you are a feminist then you are pessimistic, always looking to make a negative comment, and are a “killjoy”. However, the more undergraduate and graduate level courses I took, the more I learned that feminism is not a “bad” word. I would rather be a killjoy than stand by willingly, adjusting to society's culture of sexism, racism, and ableism. As Ahmed (2017) said “The killjoy is appealing not despite what she brings up but because of what she brings up. She acquires vitality or energy from a scene of difficulty. To be willing to be a killjoy, to be willing to get in the way of happiness, grasps hold of a judgment and takes it on” (p. 267).

I know that as a community psychologist and an intersectional feminist, values such as social justice, and empowerment, are embedded in my personal and professional life. Therefore, as an applied researcher, passionate about social justice, it is necessary that I understand and reflect on how my own positionalities impact my research choices, such as the methods I pick, the inferences I make, the questions I ask, and the conclusions I draw.

Bias and subjectivity are not bad qualities to have in research. It is important that as researchers and scholars we can share our positions that impact our worldview and consider our biases, and reflect on them. This is why I picked reflective thematic analysis for my data analysis method because it pushed me to reflect through the research process continually. Taking this step proved to be beneficial because I was constantly challenging myself to consider my positionality which helped me connect more with the research process, aiding me in my analysis. Also, one of the main aims of the current study is to amplify the voices of women with CHCs by giving them a safe space to share their experiences living in a post-Roe v. Wade world. Because of the political nature of my research study and overall interests and passions, it was important that I took a feminist phenomenological orientation with a constructionist epistemological paradigm.

While reflecting on my own positionalities and how it has impacted my research, it is important to first note that I am a white, cis-gender, middle-class woman and the majority of my participants are low-income, economically marginalized Black women. Although I do relate to my study participants because I also have a CHC that impacts my daily life, I know that my experiences are different compared to my study participants due to the privilege I have. I do not worry about being able to afford my medication or accessing any needed testing or services to treat and manage my health conditions. Throughout the research process, it was important that I continuously reflected on my privilege, separating my experiences from my participants and recognizing our embodied experiences are different due to how the different intersections of race, class, gender, and ability relate to one another in today's context.

CHAPTER 3: METHODOLOGY

3.1 Context Of The Study

The current study used a mixed-method design to examine the two research questions. A mixed-methods design is described as a study that incorporates at least one quantitative and one qualitative method (Caracelli & Greene, 1993). Research question one was addressed using quantitative data while research question two was addressed using qualitative data.

3.2 Philosophical Orientation For Qualitative Research

The qualitative research portion of this study took a feminist phenomenological orientation with a constructionist epistemological approach. Phenomenological research emerged in the early 20th century and is defined as research that aims at understanding individual experiences and then describing and interpreting them to be used as part of qualitative evidence (Cooney et al., 2012; Mayoh & Onwuegbuzie, 2015). There are different streams of phenomenology including descriptive (eidetic) phenomenology based on the work of Edmund Husserl, and interpretive (hermeneutic) drawing from the work of Martin Heidegger and Max Van Manen (Cooney et al., 2012). Descriptive phenomenology focuses on descriptions of participants' lived experiences or what Husserl called the *life world* (Cooney et al., 2012). Heidegger, a student of Husserl, sought out a different form of inquiry, interpretive phenomenology, which focuses on describing and interpreting participants' experiences (Baird & Mitchell, 2014; Cooney et al., 2012). An important focus of interpretive phenomenology is to acknowledge that experiences are linked to social, political, and cultural influences, thus making it crucial for the researcher to be aware of factors such as their biases and beliefs that could influence their understanding or interpretations (Baird & Mitchell, 2014). Phenomenology was chosen for the current study because the overturning of Roe v. Wade brought about unanticipated effects that are now impacting women with chronic conditions; however, there is little known about the specific experiences or the phenomena. Therefore, phenomenology will help shed light on these experiences or phenomena (Struther & Peden-McAlpine, 2005).

3.2.1 Feminist Phenomenology

Although phenomenology seeks out the *essence* of an experience, researchers have noted that it neglects to include forms of specific social and cultural influences or gender. Because this study focuses on the experiences of women with chronic conditions, feminist phenomenology (FP) was used, and countered any criticisms of phenomenology concerning gender. Instead, FP was used to acknowledge the influences and constraints of social structures that are placed upon women; specifically, women with chronic conditions. Allen-Collinson (2011) describes the connection between feminism and phenomenology as:

> The 'personal' of phenomenology (first-person, subjective, experientially grounded) is fundamentally linked to the 'political' (located within wider social, political, and ideological structures) (p. 121).

Feminist Phenomenology (FP) is influenced by Simone de Beauvoir's late work of interpretive phenomenological descriptions concerning gendered experience (Baird & Mitchell, 2014). FP is also built on Merleau-Ponty's notion of the lived body and embraces the mind-body connection, and aims to be inclusive of women's lived experiences in a world that is primarily seen through the eyes of men (Baird & Mitchell, 2014; Cormier, 2015; Goldberg et al., 2009). Moreover, FP enables the embodied consciousness of female subjects to be understood from a holistic mind/body viewpoint. The use of a holistic perspective takes into account the social, historical, political, personal, and cultural backgrounds; therefore, taking into account individual differences and context (Allen-Collinson, 2011; Cormier, 2015). Meaning, a woman's embodied experiences are understood with the inclusion of the social contexts and norms of society that have been placed on their embodied existence (Goldberg et al., 2009; Allen-Collinson, 2011).

Overarching, the FP framework works to bring light to the invisible so it is visible by shifting the classical foci to a deeper interpretation and contextualization (Allen-Collinson, 2011; Garry et al., 2017;). The current study aimed to shed light on the silenced voices or the *invisible* lived experiences of women with chronic conditions through the use of LCs. Furthermore, FP was chosen due to the similarities in values with LCs. The feminist phenomenological framework allows women to narrate and provide an in-depth text of their lives while speaking of their concerns, similar to what LCs provide (Cormier, 2015). Using a feminist phenomenological framework helped reach one of the study's aims: increase the visibility of larger, social issues by giving women with chronic conditions a voice to share their experiences. Additionally, the FP framework provided a greater understanding of the lived experiences of women with chronic conditions which will help future interventions to identify and acknowledge perceived inequities (Shelton et al., 2022).

3.3 Constructionist Approach

Furthermore, an epistemological or ontological approach must be considered when engaging in qualitative research because it conceptualizes how the researcher will understand their data. The present study used a constructionist epistemological approach. A constructionist approach views meaning and experiences as being socially constructed and reconstructed (Byrne, 2021). Researchers who adopt a constructionist approach perceive the word as socially constructed with people and events that exist independently of our perception of them. Additionally, a constructionist approach considers language as how one makes sense of the world, and the reality of their everyday lives is shared. Meaning, the use of shared language among individuals is used to engage in discourse, spreading shared experiences and knowledge production. Therefore, one's reality then becomes a product of their interactions with others, changing over time and place (Byrne, 2021; DeLamater and Hyde, 1998). A constructionist approach aligns with FP because it considers the complexities of the context of time and place, taking a holistic viewpoint similar to FP (Allen-Collinson, 2011; Cormier, 2015).

3.4 Ethical approval

This study was approved by the Institutional Review Board of the University of North Carolina at Charlotte before being conducted (IRB Protocol #24-0204).

3.5 Research Design

3.5.1 Study Setting

This study was conducted entirely online using Zoom and Qualtrics. An online meeting option was selected because it eliminated travel constraints, creating a more convenient location for participants to join.

3.5.2 Participants

All participants were women who had one or more CHC. Using purposive sampling, participants' eligibility included the following criteria: identified as a woman; were of reproductive age (18 - 49 years of age); had one or more CHC; lived in the South Atlantic region of the U.S.; had an annual household income less than or equal to $31,402; had access to the internet; and the overturn of Roe v. Wade impacted their health and well-being.

3.5.3 Recruitment

A non-probability, purposive sample was used for this study. To achieve a representative sample of the target population, a larger number of participants was desired to increase the statistical power of the quantitative data. The study participants were recruited through the use of multiple formats, such as flyers, social media, peers, and email. Flyers were created, printed, and distributed to different clinics (e.g., WIC and family planning clinics, women's health clinics, and OB-GYN offices) in the Charlotte, Mecklenburg County area. All flyers that were distributed to clinics or posted on social media groups were approved by an administrator (i.e., clinic staff member or social media group administrator) before being posted. The flyers included a QR code that individuals scanned which then directed them to a survey to sign up for the study. Additionally, the researcher posted about the study and survey on social media groups that were relevant to the study's topic (e.g., Facebook groups and Reddit communities for women with chronic conditions and groups for women's health issues). For example, a flyer was posted in a Facebook group dedicated to providing support for women with autoimmune illnesses, such as lupus.

3.6 Measurements

3.6.1 Screener Questions

To determine participants' eligibility, they were asked to answer seven screening questions related to gender, age, chronic conditions, geographic location, income, access to the Internet, and the impact of Roe v. Wade being overturned on their health and well-being.

Gender. The participants were presented with a question: "Which gender do you identify with?". Due to the nature of the study, the choices were limited to "woman" or "other". If the participant selected "woman", then they continued through the screener questions; however, if they selected "other" then they were presented with the survey exit message: "Thank you for your interest in participating in this research study. At this time, you do not qualify for participation. You may exit this survey by closing this screen." (survey exit message).

Age. Participants who identified as a woman were then asked a “yes” or “no” question stating, “Are you between 18 and 49 years of age?”. If the participants selected the “no” response, then their survey ended and the survey exit message was displayed. If the participant selected “yes”, then they continued through the rest of the screener questions.

Chronic Condition. The third requirement for participants was presented with the question: “Do you have one or more chronic conditions? Chronic conditions refer to a condition that lasts longer than a year, significantly impacts an individual's daily life, and requires ongoing medication attention (e.g., lupus, hypertension, Type I or II diabetes)” (March of Dimes, 2019). The participants were provided with a “yes” or “no” response choice. Participants who selected “no” received the survey exit message. Participants who selected “yes” continued through the rest of the survey.

Geographic Location. Participants were asked to verify that they lived in the South Atlantic region of the United States. The question was presented as follows : “Do you live in one of the following states: Delaware, the District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia?”. The participants were provided with a “yes” or “no” response choice. Participants who selected “no” received the survey exit message. Participants who selected “yes” continued through the rest of the survey.

Income. The fifth requirement for participants was presented as the question: “Is your annual household income less than or equal to $31,402?”. The participants were provided with a “yes” or “no” response choice. Participants who selected “no” received the survey exit message. Participants who selected “yes” continued through the rest of the survey.

Access To The internet. Additionally, participants were asked if they had access to the internet and a device with a working video camera, “Do you have access to the internet, and have a device with a working video camera?”. The question also included the note, “Please, note that this study requires participants to join a Zoom meeting with their cameras on”. Response options are listed in Appendix A.

Roe v. Wade Impact. The final requirement was presented as follows: “Has the overturning of Roe v.Wade impacted your health and well-being?”. The participants were provided with a “yes” or “no” response choice. Participants who selected “no” received the survey exit message. Participants who selected “yes” continued through the rest of the survey.

3.6.2 Demographic Questions

The following four items assessed additional participant demographics. Response options for each item are available in Appendix A.

Age. Following the screener questions, participants were asked their age using the following question: “What range reflects your current age?”.

Race. Participants were then asked questions regarding their race using the following question: “What option best describes your race?” with response options that represent current racial categories.

Ethnicity. Participants were also asked about their ethnicity. They were asked the following question: “Do you identify as Hispanic/Latinx?”.

Geographic Location. The final demographic variable asked what city and state they lived in. Participants were asked to “Please, note the city and state you live in.”. Instructions asked them to list the response as: “City, State”.

3.6.3 Additional Participant Information Questions

Following the demographic questions, participants were presented with additional questions relevant to the study. The questions addressed the number of years living with a chronic condition, the total number of chronic conditions, health care impact, CHC management impact, overall well-being impact, and knowledge of the study. See Appendix A for response options for each question.

Number of Years Living With A Chronic Condition. To address the length of time each participant has had their chronic condition, they were presented with the following question: “How long have you had your chronic condition(s)?”.

The Number Of Chronic Conditions. Participants were asked about the number and type of chronic conditions they had with the following statement: “Please, select all chronic conditions you have from the selection below.”. Responses were listed in a “select all that apply” format with 11 options.

Health Care Impact. Participants were also asked about the extent to which the overturning of Roe v. Wade had impacted their health care with the following statement: “To what extent has your health care been impacted by the overturning of Roe v. Wade?”. Responses were presented on a Likert scale with options ranging from one to five.

Chronic Health Condition Management Impact. Participants were also asked about the extent to which the overturning of Roe v. Wade has impacted their health care with the following statement: “To what extent has your chronic disease management been impacted by the overturning of Roe v. Wade?”. Responses were presented on a Likert scale with options ranging from one to five.

Overall Well-Being Impact. Participants were asked about the extent to which the overturning of Roe v. Wade has impacted their health care with the following statement: “To what extent has your overall well-being been impacted by the overturning of Roe v. Wade?”. Responses were presented on a Likert scale with options ranging from one to five.

Knowledge Of The Study. Participants were asked an additional question, “How did you hear about this study?”. Response choices were categorical.

3.6.4 Empowerment Scale

To determine the extent to which LCs promoted psychological empowerment amongst participants, the Empowerment Scale (Rogers, 1997; see Appendix B and C) was used. Drawing from multiple instruments (i.e., The Rotter Internal-External Locus of Control Instrument, the Self-Efficacy Scale, and the Rosenberg Self-esteem Scale), the Empowerment Scale was created to measure empowerment among consumers of mental health services and initially included 48 items (Rogers, 1997). The scale was subsequently refined to 25 items broken down into five subscales of self-esteem-self-efficacy, power-powerlessness, community activism autonomy, optimism and control over the future, and righteous anger (Rogers et al., 2010). However, Rogers et al. (2010) replicated the reported factor structure and found three items that needed to be removed to make the scale a more accurate reflection of the measure of empowerment. By removing the three items, the reliability and validity of the scale increased. The revised scale uses a four-item Likert scale (1 = *strongly agree* to 4 = s*trongly disagree*) and has a high internal consistency (α = .82), and the subscales have an internal consistency of α = .45 - .82 (Rogers et al., 2010).

Previous research utilizing the Empowerment Scale has predominantly focused on individuals with severe mental disorders with a broad demographic range similar to those in the current study. Specifically, like the present study sample, the scale has been used to measure the psychological empowerment of individuals with CHCs. This specific scale was chosen due to its consistency with the definition of empowerment used by Rappaport (1995) which was used to guide this study. Additionally, the scale was chosen for this study because the subscales are relevant to the target population. Each of the five subscales is relevant to women with chronic conditions and consistent with their experiences (e.g., the issue of bodily autonomy connects with subscale three).

The questionnaire was distributed with adapted scale questions to be utilized as both a pre-test and post-test survey. All pre-test survey questions were customized, to begin with, “Currently, I feel…” to capture the participant's current feelings of psychological empowerment and answer on a 5-point Likert scale (from 1 = *strongly disagree* to 5 = *strongly agree*). An example pre-test item included: “Currently, I feel powerless most of the time”. The post-test survey asked the same items, but adapted, to begin with, “After participating in the listening circle, I feel…” to capture their feelings after the completion of the intervention and to answer research question number two. An example post-test item included: “After participating in the listening circle, I feel I can often overcome barriers”.

3.6.5 Social Connectedness Scale

The Social Connectedness Scale, Revised (SCR-R) (see Appendix B and C) was used to assess the level of connectedness among participants (Lee & Lee, 2001). The SCS-R was created to assess an individual's sense of connectedness with others; specifically, their internal belief of closeness with the social world. The scale has been revised to include both positive and negative worded items to accurately assess all dimensions of social connectedness (Lee & Lee, 2001). The revised scale consists of 20 items with a high internal consistency (***α*** = .92) with a 6-point Likert Scale (from 1 = *strongly disagree* to 6 = *strongly agree*) (Lee & Lee, 2001). In past studies, samples using the SCR-R have varied widely, including individuals with CHCs.

Similar to the Empowerment Scale, the SCS-R was customized for the use of pre-test and post-test surveys. All pre-test survey items began with “Currently, I feel…” to capture the participant's current feelings while the post-test survey items will begin with “After participating in the listening circle, I feel…” to capture their feelings after the completion of the intervention and answer research question number two. For example, a pre-test survey item included: “Currently, I feel comfortable in the presence of others”. A post-test survey item included: “After participating in the listening circle, I feel I can connect with other people”.

3.7 Procedure

If a participant was interested in participating in the study after learning about it through one of the recruitment strategies, they were first presented with screener questions to determine eligibility. If the participant was eligible, then they were prompted to consent (*n* = 236) to move forward with additional questions, the LC, and pre-and post-test surveys.

3.7.1 Screener Questions

The current study was conducted online. The LCs were conducted using Zoom, and the surveys were administered on Qualtrics. Participants who were interested in the study scanned a QR code that was on the recruitment flyer (see Appendix G). After scanning the QR code, they were directed to fill out the screener survey (see Appendix A). The screener questions asked participants about their gender, age, chronic conditions, residency, internet accessibility, income, and the impact of Roe v. Wade on their health and well-being. Participants who met the study criteria were prompted to provide their informed consent to participate in the study. If the respondents did not meet the initial criteria, then they were informed they were not eligible to participate.

3.7.2 Informed Consent

Next, the participants were prompted to review the informed consent document attached as a pdf. (see Appendix F), and then provide their informed consent to participate. The consent form included the study's purpose and aims, why they were being asked to participate, what would happen if they decided to take part in the study, the benefits and risk of participation, how the data would be used, how their information will be collected, who can answer their questions, and compensation information. The consent form also specified that to participate in the study, the participant must have access to the internet on a device with video and audio recording to join the Zoom meeting. The video was not recorded but was necessary to participate. Only audio was recorded.

Once they had reviewed what was expected of them on the consent form and wanted to participate further, they were presented with boxes to check and a place to type their name in place of a signature. The boxes included statements such as, they have read and understood the information provided on the consent form attached, agree to participate, agree to the use of the data in the research projects, agree to allow the audio recording of the LCs, understand their typed name will serve as a legal digital signature, and that they understood to receive the compensation they must provide identifiable information. After checking these boxes, they typed their name in place of their legal digital signature. If the individual consented by checking all the boxes and typing their name in place of a legal digital signature, then the next screen reviewed the next set of questions they were asked (i.e., demographic and additional study-related questions).

After completing the additional questions, the participants were directed to sign up for the LC via a SignUpGenius link. The SignUpGenius was structured so that participants could only see if there was space available; meaning, the participants could not see other participants' names. Each LC date offered a total of seven to eight participant spots, so once they were full, participants could not select that date. When they selected their LC, they were asked to include their name and preferred email address (this was not shown to other participants).

3.7.3 Pre-Test Survey

Participants who completed the screener survey, provided their informed consent, and signed up for the LC received an email from the researcher 24 hours before the participants' LC date. The email included a copy of the informed consent form and a link to the pre-survey questions of both empowerment and social connectedness scale to measure their current level of psychological empowerment and social connectedness (see Appendix B). A second email reminder was sent out the morning of the LC. The email included the pre-survey link with a reminder to please complete it before joining the Zoom meeting, a link to Zoom support, the LCs Zoom link, and additional information regarding participation expectations (e.g., cameras needed to be on and compensation). The requirements to receive the e-gift card were also listed in the consent form. The choice to administer the pre-survey questionnaire before the LC date was due to the length of the surveys, and the amount of time the LC intervention was expected to take. The pre-survey questionnaire asked for the participants' names and reminded them that their names would not be attached to any of the research findings and would eventually be deleted. The reason for asking for participants' names was for the researcher to determine if any survey data needed to be eliminated from the data analysis. Participant data was eliminated if they either signed a consent form but did not complete the pre-survey or if they completed the pre-survey but did not attend the LC.

3.7.4 Listening Circle

The date and time of the LCs varied from January to March to work with the researcher and co-facilitators schedules. Each LC was conducted using a LC protocol (see Appendix D) to ensure consistency of implementation. There were five LCs, lasting approximately 60 minutes for the LC and 15 minutes for settling in and survey completion. The number of participants per LC ranged from three to eight participants. They were conducted by the primary researcher on Zoom with the assistance of another graduate student, serving as a co-facilitator. The primary researcher used a protocol (see Appendix D) to ensure that each LC was conducted in the same manner. The guide included a script for the opening and closing statements, the LC guiding values, each step of the LC process, and steps for initiating participants to fill out the post-test survey. A total of four questions were asked throughout the LCs; for example, the first two questions included “What are your day-to-day experiences with your chronic health condition(s)?” and “How has your health and well-being been affected since the overturning of Roe versus Wade?”. LCs flow in a counterclockwise rotation, and to ensure this, a circle chart (see Appendix E) was shared on the screen during the Zoom meeting. The chart displayed the first names of each participant in the current LC and was deleted after the LC ended. Each individual had the opportunity to answer each question throughout the entirety of the circle. Although each individual was encouraged to speak, to ensure that each participant had the chance to speak during the LC process and to ensure most if not all guiding questions were asked, each participant was allotted three minutes to respond to each question. The co-facilitator monitored the time, and if an individual spoke over their time, then the researcher paused the circle and asked the next individual to begin their response. The need to interrupt one of the participants was not common during the eight LCs (*n* = 3). Once the circle was completed and closing remarks were made by the researcher, compensation information was provided.

3.7.5 Post-Test Survey

Once the LC had ended, the researcher put the link to the psychological empowerment and social connectedness post-test survey (see Appendix C) in the Zoom chat. In addition to answering the measurement scales, the participants were asked if they would like to participate in the member-reflection process. Once all participants completed the survey and any final questions were asked, the Zoom ended.

3.8 Data Management

3.8.1 Listening Circles

Once each LC was concluded, the researcher exported the Zoom audio recording which was used for transcription. The audio recording was stored in a password-protected folder on the primary researcher's UNC Charlotte, student Google Drive. The audio files were only made available to the primary researcher, faculty advisor, and additional IRB-approved transcribers and research assistants.

3.8.2 Surveys

Although the pre-test survey asked for the participant's name, all final findings from the survey data remained anonymous to ensure the confidentiality of each participant as was outlined in the participant consent form. However, if participants wished to receive compensation, then their names and email address were stored in an Excel file and stored in a password-protected folder on the primary researcher's UNC Charlotte, student Google Drive. The Excel file was retained because the information is required for the University's Financial Services division as payments distributed to subjects are considered taxable income. This log is for tax purposes only and is separate from the research data, which means the names were not linked to the study data.

3.9 Data Analysis

This study used both quantitative and qualitative data analysis methods. Below are the specific steps used to achieve this design.

3.9.1 Quantitative: Surveys

The survey data was downloaded from the Qualtrics online platform into Google Sheets. For the empowerment scale and the social connectedness scale, all negatively worded items were reversed coded and added to the positively worded items to determine an individual's score of psychological empowerment and social connectedness. The higher total score on each scale reflected a higher sense of psychological empowerment and social connectedness. An assumption of normality test and paired samples t-test/dependent samples t-tests were conducted using the statistical software SPSS to compare the psychological empowerment and social connectedness pre-survey and post-survey results. A Wilcoxon signed ranks test was used if the assumptions for a paired samples t-test were not met. SPSS was also used to determine frequency distributions and central tendencies using descriptive statistics. Additionally, to make certain only relevant data was used during the analysis, LC participants who did not fill out the pre-test and post-test surveys were eliminated from the data ($n = 24$). To avoid data misrepresentation, all analyses were completed multiple times and reviewed by peers and the faculty advisor.

3.9.2 Qualitative: Listening Circles

Each LC audio was transcribed verbatim using Zoom transcriptions. After the initial transcriptions, the primary researcher listened to the audio recording and compared them to the transcription to ensure its accuracy.

The data analysis method of reflexive thematic analysis (RTA) was chosen for the current study, adhering to a constructionist epistemological approach that was used to analyze the data. Thematic analysis (TA) is a data analysis method that aims at reporting patterns or themes within a data set. By identifying, analyzing, and reporting patterns, TA allows researchers to interpret and describe rich (detailed) data (Braun & Clarke, 2006; Ho et al., 2017). However, TA is frequently misunderstood as being one all-encompassing form of TA; however Braun and Clark (2018), note there are multiple forms of TA and it is important researchers clarify which method they are using. Different TA approaches fall on a spectrum with one side being “small q” approaches and the opposite end being “Big Q” approaches (Braun & Clarke, 2020, p. 4). Both approaches use qualitative data, but small q approaches are informed by quantitative, (post)positivist research practices and values while a Big Q approach to research practices is embedded in the qualitative, non-positivist paradigm.

A small q approach includes coding reliability approaches which are orientated towards objectivity and unbiased coding by using a codebook and multiple coders for the analytic process to ensure accurate and reliable coding, therefore, inter-coder reliability is used as a key measure of coding reliability (Braun & Clarke, 2021). A form of TA that falls in between small q and Big Q approaches includes Codebook TA. Codebook TA applies a structured coding framework (e.g., framework or template analysis) for developing and documenting analysis and may apply early theme development which are all associated with the small q approaches. However, codebook TA also applies Big Q practices, such as valuing researcher subjectivity and acknowledging coding as inherently a subjective practice (Braun & Clarke, 2021).

The present study uses an inductive approach, reflexive thematic analysis (RTA) which encourages researchers to embrace their qualitative skills and subjectivity in the data analysis process, making researcher subjectivity a tool rather than a threat to knowledge production (Braun & Clarke, 2020). Therefore, the process of RTA more closely aligns with Big Q qualitative, non-positivist paradigms because it centers researchers' subjectivity and reflexivity, allowing for an organic and recursive coding process. Because the researcher's subjectivity is highlighted as a tool rather than a deficit, multiple coders are not required as a method for rigor or accuracy (Braun & Clarke, 2021). Braun and Clarke (2021) noted, “Meaning and knowledge are understood as situated and contextual, and researcher subjectivity is conceptualized as a resource for knowledge production, which inevitably sculpts the knowledge produced, rather than a must-be-contained threat to credibility” (p. 334). Therefore, inter-coder reliability risks the possibility of data becoming oversimplified, missing the richness of the data. Instead, to ensure rigor, each phase of the coding and theme development is well-documented by the researcher and then reported in detail in the final write-up. This provides an audit trail and demonstrates the researcher is dedicated to being transparent and reflective (e.g., memoing, peer debriefing, and prolonged engagement with the data) throughout the entirety of the data analysis process.

RTA was chosen for the present study because it aligns most with the community psychology values of constantly reflecting on one's positionality and subjectivity, going beyond including a positionality or subjectivity statement. Additionally, because I am a novice qualitative researcher, RTA was beneficial because it required me to reflect on what I was doing and thinking. Thus, strengthening my understanding of RTA and qualitative research while allowing me to fully immerse myself in the data. Additionally, RTA aligns most with feminist phenomenology and a constructionist epistemology as it emphasizes that embodied experiences are situated within their context of time and place; therefore, knowledge production is constantly evolving and cannot be purely objective because you cannot remove subjectivity (Allen-Collinson, 2011; Cormier, 2015).

Furthermore, RTA was chosen as the data analysis technique for the qualitative data because it can be used as a hermeneutic phenomenological approach that identifies themes and is a useful strategy when making known embedded or hidden meanings in transcription (Ho et al., 2017). This means that the researcher emphasizes the need to conserve ontological possibilities by shedding light on the hidden or unspoken interpretations through the action of "dwelling" in language. For researchers to "dwell" in language, they engage in reflective and self-awareness practices, such as reflecting on the meaning and conditioned understanding of everyday or "ready-at-hand" language (Braun & Clarke, 2021; Ho et al., 2017). Additionally, it is a useful technique when presenting robust and sophisticated results while also wanting to make them accessible to all individuals including those outside of academia such as the population of this study (Braun & Clarke, 2014). There are six essential and recursive steps to complete RTA which include: 1) data familiarization; 2) systematic data coding; 3) generating initial themes; 4) developing and reviewing themes; 5) refining, defining, and naming themes; 6) writing up (Braun & Clarke, 2021). After completing the final step of the RTA process, the researcher included relevant participant quotes to demonstrate the pervasiveness of the themes across the data and the essence of arguments or points while excluding identifiable information (Braun and Clarke, 2021; Van Gaelen et al., 2021).

3.10 Quality And Rigor

Multiple methodological strategies were used for both qualitative and quantitative methods to ensure substantive quality and rigor in the study.

3.10.1 Quantitative

Quantitatively, research methods, research design, sampling, instruments, data collection, and data analysis are the main components to establish rigor (Baker, 2017; Kim and Park, 2019). The current study uses surveys as a data collection method. To verify the rigor of the research study instruments, each instrument being used was selected because it was found to be aligned in construct and psychometrically validated. Additionally, to ensure conclusions could be drawn based on the instruments, both the empowerment scale and social connectedness-revised scales were examined to certify high reliability and validity (Laher, 2016). Moreover, the researcher has described each instrument in detail. The following criteria were described by the researcher in the study to make certain there was sufficient detail of each instrument: what the instrument measures, what the subscales are and what they measure, and response formatting (Laher, 2016). For the final component of quantitative rigor, the researcher tested for assumptions of normality. Testing for normality determined if the data follows a normal distribution curve (i.e., most of the data will fall at the center and be close to the mean) (Kim & Park, 2019). If the data created a normal distribution, then the researcher knew if there was a difference between the pre-test and post-test survey responses. Satisfaction of normality assumptions was crucial because a t-test was used (Kim & Park, 2019). A t-test is used to compare the characteristics of different groups, using the mean values when the population has a normal distribution (Kim & Park, 2019). Furthermore, to maximize the power of both the normality test and t-test, the sample size for the current study was 33.

3.10.2 Qualitative

Trustworthiness in qualitative data establishes the credibility, transferability, dependability, confirmability, and integrity of the data (Anney, 2014; Nowell et al., 2017). To make certain the research findings are trustworthy, the following actions were taken by the researcher: engaging in reflexivity practices, prolonging engagement with the data, engaging in peer debriefs, holding member reflection sessions, and including a transparent write-up (Anney, 2014; Nowell et al., 2017; Stahl & King, 2020; Tracy, 2010). The above practices used to establish trustworthiness are described below.

RTA encourages the researcher to constantly engage in reflexivity which is described by Finlay (2021) as the researcher's “openness, self-awareness, and ethical sensibility” (p.113). Engaging in reflexivity makes the researcher question their position and subjectivity (Castleberry & Nolen, 2018; Finlay, 2021; Nowell et al., 2017). For the present study, the researcher engaged in memoing throughout the data analysis process and annotated transcripts to aid in their reflexive practices. The strategy of prolonged engagement included the researcher thoroughly reading the transcribed data multiple times to become familiar with the data before coding. Another strategy that was used included the action of peer debriefing/peer critiquing, enhancing the plausibility and acceptability of all findings. This strategy included the researcher debriefing after each LC with the session co-facilitator. A meeting with the researcher's advisor and the co-facilitator was also scheduled so that the researcher could present their generated themes, reflect on their analysis process, and ask for valuable feedback, such as if the themes were understandable. Moreover, after receiving feedback from the researcher's advisor, participants were invited to engage in a member reflection session. Member reflections added a level of credibility to the data because they “allow sharing and dialoguing with participants about the study’s findings, and providing opportunities for questions, critique, feedback, affirmation, and even collaboration on the final analyses of the data" (Tracy, 2010, p. 884). The sessions were not meant to make sure the researcher “got it right”, rather it was a space for reflexive collaboration (Tracy, 2010). In addition, it was important that the researcher was transparent about their research process; specifically, noting how they immersed themselves in the data, how they engaged in reflexive practices, and what emerging thoughts and questions came up during the analysis (Tracy, 2010). By being transparent in the research process, the researcher was able to achieve a greater sense of sincerity in their qualitative research (Tracy, 2010). Outlined below are the six RTA steps.

Phase One: Data Familiarization. The first phase of data analysis began directly after each LC, where I debriefed with my LC co-facilitator. During our debriefs, we discussed what went well and what could be improved for the next circle. For instance, after the first LC, we noted that I should say the questions used for the LC out loud to participants and paste the questions in the chat box. This ensured the participants knew what questions were being asked in case they forgot when it was their turn or if they could not hear due to technical issues with their wifi connection. We also discussed what we found interesting and surprising from what the participants shared during the LC. Engaging in peer debriefing at this phase of the research process allowed me to constantly engage in reflexive practices, encouraging me to question any assumptions and talk through questions I had. Additionally, during all LCs and after debriefing with the co-facilitator, I engaged in the practice of memoing, which involved writing about how I felt during the LC and reflecting on my positionality. The second part of this phase included uploading the LC audio, transcribing all LCs, and comparing the transcriptions to the audio multiple times to ensure prolonged engagement with the data. During the transcription process, I took note of anything that stood out to me and reflected upon what the participants said through memoing, again engaging in reflective practices. By engaging in reflective memoing throughout this phase of the analysis and engaging in peer debriefing early on, I was able to constantly question my positionality and reflect on any assumptions I was making early on.

Phase Two: Systematic Data Coding. The second phase of the analysis included systematically coding the transcriptions. After transcribing each LC, three research assistants (two undergraduate students and one graduate student) reviewed the transcriptions, comparing them to the audio and adding an extra layer of accuracy to the transcribed audio. I then systematically coded each LC, using the comment feature of Google Docs. Using the comment feature allowed me to go back and make updates to the codes while keeping a history of the code development.

After the first round of coding, I again engaged in memoing, reflecting on what codes I was generating. During the first round of coding, I noticed that most of my codes were mostly semantic; meaning, they were descriptive and focused solely on the explicit meaning compared to latent coding which includes coding at the implicit level of meaning, making interpretations, and conceptualizing within the data (Campbell et al., 2011). I found myself using semantic coding because I was worried that I would misinterpret what my participants were saying. Also, I was constantly worried that I was coding incorrectly, resulting in me going back to the literature. After reading through the literature, I found that my worry and feeling of coding wrong was a common feeling, especially for now qualitative researchers like myself. Going back into the literature and finding the resources provided me with the reassurance that I needed as I went back to my transcriptions and engaged in additional rounds of coding. A quality of RTA includes constantly reflecting and allowing your data to evolve as you continue to immerse yourself in the data, therefore coding was a recursive process. While engaging in multiple rounds of coding, I became more comfortable with the data and with the process of coding at the latent level. After completing multiple rounds of coding and memoing, the number of codes that I went into phase three with was a total of 150.

Phase Three: Generating Initial Themes. Moreover, I exported all of my coded data to a Google Sheet, so all codes and respective quotes were located in one document, making generating themes more efficient. While reviewing the coded data, I reduced the candidate codes to ones that were relevant to my research question. After this step was complete, I moved and clustered codes into different groups based on patterns and relationships, creating my first set of themes. During this process, I continuously returned to the transcriptions to ensure my themes and codes closely matched what the participants were saying, allowing me to stay fully immersed in the data. After multiple rounds of revision to both the codes and themes, I generated a total of four themes that I found to be meaningful and representative of the data.

Phase Four: Developing And Reviewing Themes. During phase five, I revised my themes by going through all the codes in detail, ensuring they fit the theme they were placed in. I then engaged in another round of peer debriefing with my advisor and co-facilitator. Prior to the meeting, my advisor and the co-facilitator read all the transcripts. We met for one hour to review the themes and codes I generated. During this meeting, I shared the themes I generated and received feedback about the completeness, clarity, and comprehensibility of the themes. After receiving feedback and reflecting on my analysis process, I went back to my data, making edits to the theme's descriptions and names and adding definitions to all of the codes that encompassed each theme. Adding definitions to the codes proved to be extremely helpful because it clarified the boundaries of the themes. After I applied the feedback, I shared my final themes with my advisor for one last round of comments.

Phase Five: Refining, Defining, And Naming Themes. After the themes were reviewed for clarity, I scheduled six, 30-minute member reflection sessions with my participants. Each session had a maximum of five participants. A total of 23 members participated across the eight sessions. During the meetings, I shared a brief presentation, highlighting each theme including its description and quotes. I then invited feedback and provided room for participants to reflect on their experiences during the LC and the member reflection session. Participants reflected that the themes were easy to understand and the data were enlightening. In addition, they communicated that they were appreciative of being able to participate in both the LC and member reflection and that both experiences brought a sense of community. The member reflection process was beneficial because it allowed me to engage in another form of reflexivity with my participants and it provided a level of reassurance that I had synthesized the data according to participant experiences.

Phase Six: Writing The Report. The final phase of the RTA process involved making final adjustments to the themes based on the member reflection sessions. Adjustments included clarifying theme descriptions and ensuring the quotes used in my final write-up had sufficient context to back up my themes. I then went back to the codes and read through my transcriptions a few more times, ensuring no important omissions. The final write-up of my analysis highlights each theme in detail with de-identified supporting quotes.

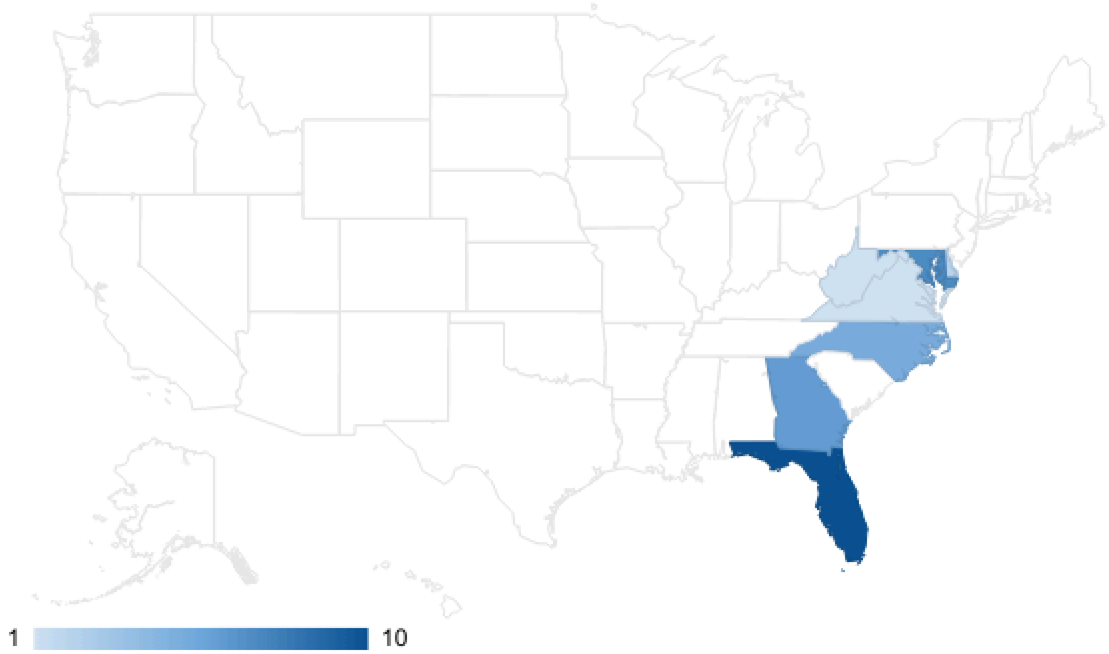
CHAPTER 4: RESULTS

4.1 Demographic Characteristics

The current study included 33 participants (demographic characteristics can be found in Table 1). Most participants were between the ages of 29 and 39 (51.5%; *n* = 17), identified as Black/African American (75.8%, *n* = 25), and non-Hispanic/Latinx (90.9%; *n* = 30). When asked "*How long have you had your chronic health condition(s)?*", the majority of participants indicated between 1 and 5 years (81.8%; *n* = 27). Participants were also asked to report which CHCs they have; 45.5% (*n* = 15) have chronic diabetes, 15.2% (*n* = 5) have hypertension, 15.2% (*n* = 5) have cardiovascular disease, 12.1% (*n* = 4) have Alzheimer disease, 12.1% (*n* = 4) have Cancer, 9.1% (*n* = 3) have respiratory disease, 6.1% (*n* = 2) have chronic kidney disease, and 6.1% (*n* = 2) have chronic heart disease. Additionally, 12.1% (*n* = 4) selected "other" as a choice and typed in a response that included migraines, inflamed gut, eating intolerances, sciatica, Sjögren's syndrome, and chronic anxiety. Among the participants, 33.3% (*n* = 11) have two or more chronic conditions. In addition, participants were asked to identify which state in the South Atlantic region of the U.S. they lived in; participants indicated the following: Florida (30%; *n* = 10), Maryland (21%; *n* = 7), Georgia (12%; *n* = 6), Delaware (6%; *n* = 2), North Carolina (15%; *n* = 5), District of Columbia (3%; *n* =1), Virginia (3%; *n* =1), and West Virginia (3%; *n* =1) (see Figure 1).

Figure 1

Geographic Location of the Sample



Note. States are filled in with a gradient color. The darker the blue color, the greater the number of participants from that state. Florida had the most participants (*n* = 10) while Virginia, the District of Columbia, and West Virginia had the least (*n* = 1). No participants were from South Carolina.

Table 1

Demographic Characteristics of the Sample (N=33)

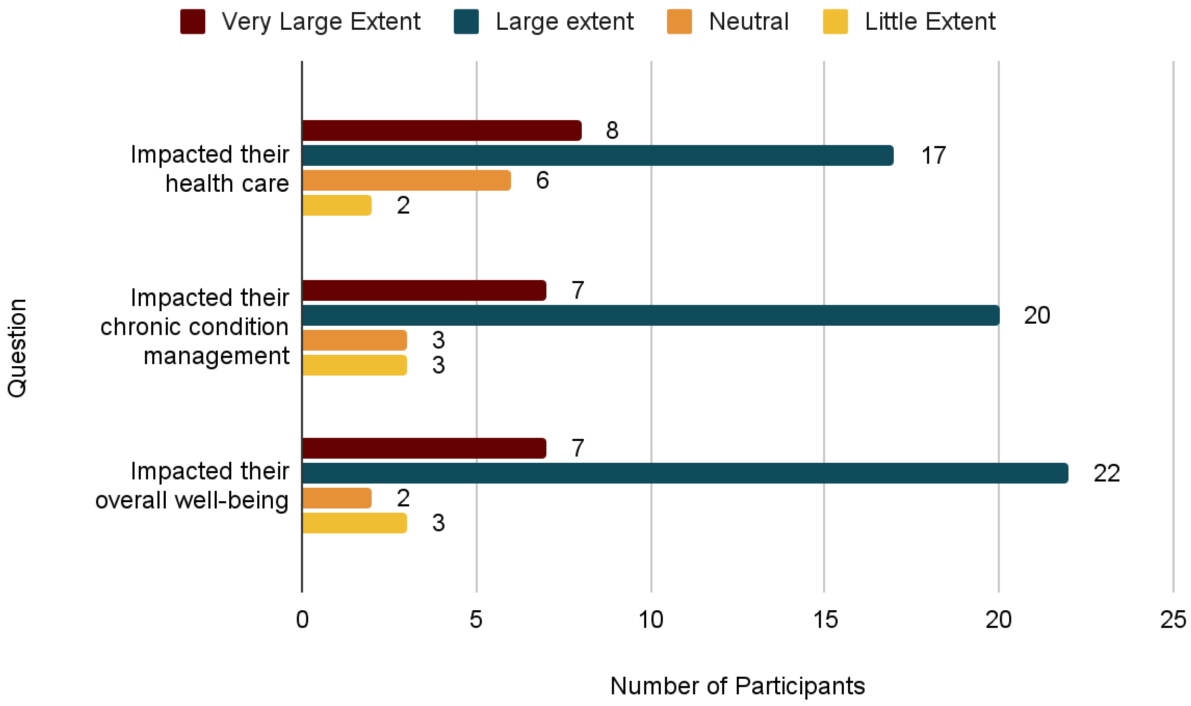
Demographic Characteristics	*n*	%
Age (years)		
18-28	13	39.40%
29-39	17	51.50%
40-49	3	9.10%
Race		

Black/African American	25	75.80%
Black/African American and White	1	3.00%
White	7	21.20%
Ethnicity		
Hispanic/Latinx	3	9.10%
Not Hispanic/Latinx	30	90.90%
Length of Chronic Condition(s) (years)		
1 - 5	27	81.80%
6 - 10	4	12.10%
11 +	2	6.10%
Chronic Health Condition(s)		
Alzheimer's disease	4	12.10%
Cardiovascular disease	5	15.20%
Cancer	3	901%
Chronic diabetes	15	45.50%
Chronic heart disease	2	6.10%
Chronic kidney disease	2	6.10%
Hypertension	5	15.20%
Respiratory disease	3	9.10%
Other	4	12.10%

Participants were asked three questions about how Roe v. Wade being overturned has impacted their health and well-being (see Table 2). The response options for all three questions were presented on a scale of 1 to five (1 - *little extent*; 5 - *very large extent*). When asked about to what extent the overturning has impacted their health care, participants indicated a large to a very large extent on average (*M* = 3.94, *SD* = 0.83) with most participants selecting the policy overturn has impacted their health care to a large extent (51.5%; *n* = 17). When asked about what extent the overturning has impacted their chronic condition management, participants indicated a large to a very large extent on average (*M* = 3.94, *SD* = 0.83) with most participants selecting the overturning has impacted their CHC management to a large extent (60.6%; *n* = 20). When asked about what extent the overturning has impacted their overall well-being, participants indicated a large to a very large extent on average (*M* = 3.94, *SD* = 0.79) with most participants selecting the overturning has impacted their CHC management to a large extent (66.7%; *n* = 22).

Table 2

Results of Participant Responses About the Impact of the Overturning of Roe v. Wade on Their Health and Well-Being



Note. Questions are from the screener survey (see Appendix A).

4.2 RQ #1: How Effective Are Listening Circles In Promoting Social Connectedness And Psychological Empowerment For Women With Chronic Health Conditions?

4.2.1 Psychological Empowerment

A paired-sample t-test was conducted to compare participants' levels of empowerment before and after participating in the LC. A Shapiro-Wilk test indicated that the differences between the participant's pre-test and post-test scores were normally distributed, $W = 0.97(33)$, $p = 0.52$. Participants scored significantly higher after participating in the LC ($M = 3.19$, $SD = 0.29$) compared to before ($M = 3.01$, $SD = 0.29$), $t(32) = 3.01$, $p = .003$. The effect size was medium, $d = 0.52$. When comparing the pre-test and post-test scores by subdomain, a Shapiro-Wilk test indicated that the differences between the participant's pre-test and post-test scores were normally distributed and a paired-sample t-test was conducted to compare participants' subdomain levels of empowerment before and after participating in the LC (see Table 3). The subdomain righteous anger was not normally distributed, thus, a non-parametric Wilcoxon signed ranks test was conducted (see Table 4). Only two subscales demonstrated that participants scored higher after participating in the LC. Participants scored higher in the subdomain power-powerlessness and community activism and autonomy after participating in the LC. However, outliers were identified for both subdomains and a non-parametric test was run to determine significance. Because outliers were identified for the power-powerlessness subdomain, a Wilcoxon signed ranks test was conducted and the output indicated that the post-test scores ($Mdn = 2.43$, $n = 33$) were significantly higher compared to the pre-test scores, ($Mdn = 2.00$, $n = 33$), z = -2.69, $p = 0.004$. The power-powerlessness subdomain measures one sense of decision-making power (Rogers et al., 1997). Because outliers were identified for the community activism and autonomy subdomain, a Wilcoxon signed ranks test was conducted and the output indicated that the post-test scores ($Mdn = 3.67$, $n = 33$) were significantly higher compared to the pre-test scores, ($Mdn = 3.33$, $n = 33$), $z = -1.94$, $p = 0.03$. The community activism and autonomy subdomain measures an individual's feeling of the effectiveness of change for one's life and community (Rogers et al., 1997). The five subscales' descriptive statistics and the results from the paired samples t-test and Wilcoxon signed ranks test are outlined in Table 3 and Table 4 below.

Table 3

Descriptive Statistics and Paired Samples t-test Results for Self-Esteem-Self-Efficacy and Optimism and Control Over the Future Subscales of the Empowerment Scale

	M	SD	S.E. mean	Paired *t*-test		
Subscale				*t* value	*df*	*p*-value
Self-esteem-self-efficacy						
Pre	3.33	0.44	0.08	1.19	32	0.12
Post	3.44	0.34	0.06			
Optimism and control over the future						
Pre	3.24	0.47	0.08	1.41	32	0.09
Post	3.38	0.48	0.08			

Note. A Shapiro-Wilk test indicated that the differences between the participants' pre-test and post-test subscale scores were normally distributed.

*Significant at the 0.05 level (1-tailed)

Table 4

Descriptive Statistics and Wilcoxon Signed Ranks Test Results for the Power-Powerlessness, Community Activism and Autonomy, and Righteous Anger Subscales of the Empowerment Scale

	M	SD	Wilcoxon Signed Ranks Test		
Subscale			z^a	*df*	*p*-value
Power-powerlessness					
Pre	2.38	0.43	-2.69	32	0.004*
Post	2.65	0.5			

Community activism and autonomy					
Pre	3.38	0.4	-1.94	32	0.03*
Post	3.55	0.36			
Righteous anger					
Pre	2.35	0.61	-0.9	32	0.18
Post	2.41	0.78			

Note. A Shapiro-Wilk test indicated that the differences between the participants' pre-test and post-test subscale scores were normally distributed. A Wilcoxon Signed Rank Test was used if the subdomain did not meet the assumptions for a paired sample t-test.

*Significant at the 0.05 level (1-tailed)

[a]Based on negative ranks.

4.2.2 Social Connectedness

A paired-sample t-test was conducted to compare participants' levels of social connectedness before and after participating in the LC. A Shapiro-Wilk test indicated that the differences between the participants' pre-test and post-test scores were normally distributed, $W = 0.96(33)$, $p = 0.30$. There was one outlier identified and removed. Participants scored significantly higher after participating in the LC ($M = 4.74$, $SD = 0.63$) compared to before ($M = 4.22$, $SD = 0.72$), $t(31) = 3.68$, $p = .001$. The effect size was medium, $d = 0.63$.

4.3 RQ #2: How Has The Overturning Of Roe V. Wade Impacted The Health And Well-Being Of Women With Chronic Health Conditions?

There were a total of eight LCs, and each circle had a range of three to seven participants ($M = 4$). All participant quotes are de-identified to ensure privacy. An RTA of the qualitative data revealed four overarching themes: 1) limited access to reproductive healthcare; 2) navigating new uncertainties is psychologically draining; 3) exacerbated health inequities; and 4) decreased personal agency and autonomy (see Table 5).

Table 5

Generated Themes

Theme Name	**Description**	**Example Quotes**
Limited access to reproductive healthcare	The overturn of Roe v.Wade has limited access to reproductive healthcare which is a basic human right and part of one's comprehensive healthcare. Consequently, limiting women's reproductive healthcare increased barriers to accessing treatment for chronic health conditions.	1) “Access to these healthcare services, including abortion and contraceptives is quite vital for my well-being.” 2) “I think it's not being considered was, it could be an option to save my life.” 3) “There’s a period where I um, I went to the pharmacy and I’m going to get some drugs, but I couldn’t get them cause I think the drugs were used for medicated abortions.” 4) “I would say uh someone living with arthritis like me, I think it’s just become a problem even getting some drugs.” 5) “To me not having the right to abortion is uh is like a fundamental right being deprived for me, and this is going to affect me adversely because it's some of the things I would want to have total control over which I wouldn't want anyone to make the decision.”
Navigating new uncertainties is	On top of dealing with the mental toll of their chronic health condition,	1) “I feel like it just increased my anxiety when I first found

psychologically draining	the uncertainty of new abortion bans and restrictions has caused a new level of fear and stress, worsening their mental health and other chronic health conditions.	out that they overturned Roe v. Wade, I thought the world was going to end.” 2) “I'm afraid that probably if I get pregnant and then with the treatment, I might have to pause it, which poses a health hazard.” 3) “When Roe v. Wade was overturned, that has become just another intrusive thought that swims in my head. Umm. It just exacerbated every… all of my anxious thoughts, OCD, intrusive thoughts, and my health concerns.” 4) “I'm not going to have full control of how I make decisions concerning me, and this alone is enough to, you know, make someone feel depressed, make someone feel unwanted, and make someone feel that they are lacking, so many things they have the right to.” 5) “I can't abort the child and it affects my thinking, making my condition a bit intense it affects me so heavily that it may lead to the persistence of the chronic disease and lead to other chronic diseases and much infection to my muscles, and too much tension, and I may lose the baby in such a period, whether in my liking or not, and this has really affected me by thinking and my well-being.”

Experiencing exacerbated health inequities	New bans and restrictions have exacerbated health inequities due to the intersection of race, class, gender, and ability, disproportionately affecting Black women's access to equitable healthcare.	1) "Negatively affecting young people, most of all black women." 2) "When you are a person of color when something like that happens, it's really hard to access such services and you maybe have to get someone else to help you get the drugs that you need, which honestly is not a good thing because sometime you do not know other person that can help them or they are unable to actually access them." 3) "The necessary things that are needed to help me to come off of depression and bad health state are quite limited… and the sad thing about it is because I'm black and people tend to treat me as they like, and it's not quite encouraging. It messes deeply with my mental state."
Decreased agency and autonomy	With the government getting involved in women's reproductive healthcare, their autonomy has been threatened and reduced, impacting their agency (e.g., the ability to act or behave as they want) and limiting their range of choices for managing their health. This is leading them to feel like they have no control or say over their lives and are being forced to do things they do not want.	1) "Forcing me to kind of adhere to whatever the government says versus what myself and how I'm feeling." 2) "I don't feel like I have much right for my body. You're like, yeah someone has a whole lot of authority over me." 3) "I have issues taking part in any sexual activities because out of fear of getting pregnant." 4) "It's like I'm going to have

		to give up my life if I am going to bring in another life here, so I feel not so ready to do that. I just have to sacrifice my life at some point.”

4.3.1 Theme One: Limited Access To Reproductive Healthcare

The first theme generated refers to the overturning of Roe v. Wade’s impact on participants' access to reproductive healthcare services and treatment which is part of comprehensive healthcare. Comprehensive health care includes access to and opportunity to reproductive healthcare and CHC treatment and services and is considered a basic human right (United Nations Human Rights Office of The High Commissioner, n.d.). During the LCs, participants were asked questions about their experiences living in a post-Roe v. Wade world, and one of the major themes mentioned in their responses was their frustration with being denied access to healthcare services, such as abortions. Having access to reproductive healthcare services, including abortions is an important part of preventative care because it can help prevent injury, infection, or long-term health issues (Centers for Disease Control and Prevention, n.d.). Participants said “Access to these healthcare services, including abortion and contraceptives is quite vital for my well-being” and “I can say being a woman with diabetes, access to reproductive health care has always been crucial for me”. The policy overturn is negatively impacting their long and short-term health and well-being by impacting their access to needed reproductive healthcare services. Having access to abortions is vital for women; specifically women with CHCs because it could potentially save their lives. For instance, a few participants described how abortions could serve as a life-saving procedure because caring for a child could cause them harm due to their CHC. Three participants stated:

> So I think by them overturning the law on abortion, I think it's not being considered was, it could be an option to save my life or to save the yeah, actually to save my life because of my condition.
>
> I feel abortion is the better option or is the best option to save me as having a health condition and not being able to carry a child. I’m unable to take care of that child, my healthcare, health condition.
>
> I also think the law should be able to allow opportunities and chances for drastic decisions when a woman is in a condition that needs an impromptu decision so that he can be able to save, she can be able to save her life.

Additionally, the overturn of Roe v. Wade brought on unanticipated effects, including limiting access to CHC-specific medication, services, and treatments. Because some medications used for abortions are used to treat CHC (e.g., methotrexate and misoprostol), individuals who use these medications daily are finding it more difficult to access them (Suran, 2022). Participants also said the following about new medication restrictions and their effect on their health and the health of other women with CHCs.

> Okay, and now with this overturning it has affected everyone because the drugs won't be available to us. It won't be available to us when we need it. I just think it’s harder for people with disabilities with this whole thing. I mean, if you don't have any like chronic illness, I think it it stays hard, but then us that do have, you have to compare and check on with drugs or you know to contradict…contradict the ones you take all those things. Yeah, so…I feel it's gonna cause us more harm than good.
>
> They should really consider people, the youth who are the most sexually active, in the hierarchy, and also they should consider the people that are chronically ill. The people

> that need these, are the people with cancer. People with arthritis, people with all these sorts of chronic illnesses, they should consider them because these people need some certain type of medications.
>
> I would say uh someone living with arthritis like me, I think it's just become a problem even getting some drugs. For people living with chronic illness. Let's just talk about me.
>
> So I think well this has affected most of us living with chronic illnesses, especially people that need some types of medication to get better or some medications that we really rely on on a daily basis. It has become a problem because we are unable to access those drugs and there's nothing we can actually do about it.

As a result, participants described going to extremes to ensure they have access. For example, one participant stated, "We have to go deeper and get these drugs illegally because they're not available now we're not given them easily". Also, one participant recounted an experience where she went to pick up a prescription from a pharmacy but was questioned why she needed the medication and if she was pregnant. The participant said the following:

> There's a period where I um, I went to the pharmacy and I'm going to get some drugs, but I couldn't get them cause I think the drugs were used for medicated on abortion, and I had to prove that I wasn't pregnant at the time so I could get the drug that I needed.

Moreover, some participants noted that they had seen an increase in the prices of their medications. A participant said, "My major challenge was the increase in prices…medications…and getting the services". Limiting access to needed healthcare services to participants is "not really good experience it's more like my human right and I'm being deprived of it and it has really, really affected me generally. I've been restless". Similar to this participant's shared experience, other participants often noted that denying them access to abortion services was denying them a human right. For example, “So I think it’s a right that we should be given a chance to choose whether you will keep a child or not because it’s your right” and “To me not having the right to abortion is uh is like a fundamental right being deprived for me, and this is going to affect me adversely because it's some of the things I would want to have total control over which I wouldn't want anyone to make the decision”. Access to comprehensive, quality healthcare is a basic human right (United Nations Human Rights Office of The High Commissioner, n.d.). Reproductive healthcare, including abortions, is part of comprehensive healthcare as well as treatment and services for CHC, and both are vital to the health and well-being of women; specifically, women with CHCs (Centers for Disease Control and Prevention, n.d.; Tanne, 2022; Verbeist et al., 2022. Therefore, the overturning has impacted their ability to effectively treat and manage their CHC, withholding them from their basic human right to quality comprehensive healthcare.

4.3.2 Theme Two: Navigating New Uncertainties Is Psychologically Draining

The overturning of Roe v. Wade has mentally been difficult for participants. On top of dealing with the mental toll of their CHC, the uncertainty of abortion bans and restrictions has caused a new level of fear and stress impacting their everyday lives. Participants said it is “Really difficult living with uncertainty”. The severity of fear and stress participants are feeling is worsening their mental health and other CHCs.

The atmosphere created by the overturn of the policy itself was overwhelming and stressful. Participants said “So basically, it's more of my mental health that has been affected” and Roe v. Wade being overturned has “made my anxiety much worse”. Living with a CHC is already mentally tasking as described by the participant quotes below.

> Then to add up to the Wade law, not some having abortion these two are really going to make my experiences to be worse because I'm gonna be dealing with like, dealing with two different conditions, dealing with dealing with chronic conditions, and also dealing with some trying not to get pregnant and look like someone who is already managing chronic conditions, you already stress, both, both mentally, physically and otherwise. And then you are also stressing out about your abortion rights.
>
> It affected so many areas of your life, even in your job, even the way you perceive yourself is affected and um it's also affected that, oh, I'm not going to have full control of how I make decisions concerning me, and this alone is enough to, you know, make someone feel depressed, make someone feel unwanted it, and make someone feel that they are lacking, so many things they have right to.

Another participant said, "I feel like it just increased my anxiety when I first found out that they overturned Roe v. Wade, I thought the world was going to end". Participants who outwardly stated they already struggled with persistent mental health issues said "When Roe v. Wade was overturned, that has become just another intrusive thought that swims in my head. Umm. It just exacerbated every… all of my anxious thoughts, OCD, intrusive thoughts, and my health concerns". Thus, the addition of uncertainty caused by the policy change exacerbated any mental health struggles participants were already experiencing in their day-to-day lives. This new stress and anxiety is not healthy for individuals with CHCs who are advised by health professionals to avoid unnecessary stress. Below is a quote by a participant describing how additional stress is not beneficial to them because of their diabetes.

> It has really increased diabetic pressure and you're not supposed to, you're not. It's like, you know, stress yourself. And like worry so much about a thing. So I think it has really

> made me to worry so much about the overturning of Roe v. Wade, so my health condition, so my well-being has been affected so badly.

Another participant stated that the additional stress of potentially not having the ability to have an abortion if they chose could also result in another CHC.

> I can't abort the child and it affects my thinking, making my condition a bit intense it affects me so heavily that it may lead to the persistence of the chronic disease and lead to other chronic diseases and much infection to my muscles, and too much tension, and I may lose the baby in such a period, whether in my liking or not, and this has really affected me by thinking and my well-being.

Abortion access is essential for women and women with CHCs because it provides them a "sense of security". For example, participants said, "Knowing that I had the right to make decisions about my reproductive health without unnecessary barriers", "Since, the ruling changed how I felt heightened, heightened sense of uncertainty and anxiety, so I worry about the implications of my own health", and "I'm super paranoid now. I'm always double, triple, and quadruple checking on like my birth control methods, making sure that I have to be extra cautious". Without the security of abortion procedures and services, participants explained that "You don't know what will come along. You don't know if something will happen to you if you're able to carry it out or if you're not able to, or something may just happen, so there is too much fear". Specifically, participants spoke about their fear of breaking laws and what that would mean for them and potentially their doctors. For example, a participant said, "It's not safe for me to go and have the procedure because they could arrest me. They could arrest my doctor and the doctor too". Other areas of fear participants discussed included the fear of becoming pregnant because it could impact their treatment for their CHC. For instance, a participant said, "I'm afraid that probably if

I get pregnant and then with the treatment, I might have to pause it, which poses a health hazard, it brings a health problem to me". Also, participants were afraid of the financial impact of pregnancy and caring for a child and how that could impact them or their families. One participant spoke of feeling like they would be a burden to others around them in the following quote:

> It will be a burden to everyone around me, especially if we are not we are not financially capable. Like who is going to take care of the child? Because literally, I'm not in a position to take care of that child that I have to take care of.

Furthermore, women fear pregnancy not just because of what it could mean for them and their health, but because they are fearful for the future of their child's life living in a post-Roe v. Wade world. For example, a participant described that they do not want their child to experience the world that they are currently living in, stating "Every night before I go to sleep one of my prayers is 'please God do not let me have a girl' because I don't want her to experience this country and this society and the misogyny".

4.3.3 Theme Three: Experiencing Exacerbated Health Inequities

The effects brought on by the overturning of Roe v. Wade are significantly worse for women of color; particularly, Black women with CHCs. Participants described the overturning as "negatively affecting young people, most of all black women", and "for a black lady like us, it is, really, it's terrible for us". For instance, the overturning has only exacerbated these health inequities because it brought new restrictions and bans. For instance, in the quote below, a BIPOC (black, Indigenous, and other person of color) participant described how accessing needed healthcare services and treatment has become more complicated and they are having to find other ways to ensure they can treat and manage their CHC.

> Especially for someone of color like me, it has become an even bigger problem. It has become an even bigger problem since when you are a person of color when something like that happens, it's really hard to access such services, and you have maybe to get someone else through someone else to help you get the drugs that you need, which honestly is not a good thing because someone that does not know another person that can help them, they are unable to actually access them.

Moreover, constantly having to deal with discrimination and prejudice from others can negatively impact one's mental health (Brownlow et al., 2021; Simons et al., 2021). Participants spoke of interacting with doctors as a black woman, speaking to how the intersection of race and ability (living with or without a CHC) dictates their quality of treatment or services, "but it's actually not, and the sad thing about it is because I'm black and people tend to treat me as they like" and that the treatment is "not quite encouraging. It messes deeply with my mental state". Black women with CHCs experience disproportionate quality healthcare services, often due to discrimination and prejudice directly from their healthcare providers (Hassan et al., 2023; Martin et al., 2023). Participants are worried about future conversations with their providers about pregnancy and motherhood because they "already struggle enough just getting my doctors to understand me. When I discuss my symptoms about my chronic health issues, throwing in abortion and potential pregnancy and motherhood into the mix just makes everything even more convoluted". Therefore, the overturning has only made accessing and receiving healthcare more difficult for marginalized individuals.

4.3.4 Theme Four: Decreased Agency And Autonomy

The term agency is defined as "the ability to take meaningful actions, make decisions, and influence the world around us. It underscores our capacity to act independently and be drivers of change” while autonomy is defined as “our right to make choices regarding our own lives without external pressures or interference. It places a spotlight on our freedom to decide based on our personal values and desires” (Taylor, 2023). Participants reported that living with a CHC takes a piece of their identity, agency, and bodily autonomy away because their CHCs affect many facets of their lives. One participant said “So for me, my bodily autonomy is already low, because I am subjected to what my health dictates”, thus because of the external influence (ie., chronic health condition), individuals with CHC have a low sense of bodily autonomy which impacts how they live their lives (agency).

With the overturn of Roe v. Wade, the government is now more involved in women's reproductive healthcare, threatening their autonomy as a result and decreasing their agency (e.g., the ability to act or behave as they want). The overturning has stripped them of another option of “choice” and “control” leading them to feel like they have no control or say over their lives and are being forced to do things they do not want. Examples of how participants talked about feeling forced included “Forcing me to kind of adhere to whatever the government says versus what myself and how I'm feeling”, “I don't feel like I have much right for my body. You're like, yeah someone has a whole lot of authority over me”, and “I felt like that right to make a decision was somewhat stripped from me”. In the three quotes, all three participants talk about how the ability to make a decision or choice was taken from them by an external influence (government) or authority; thus, they are being forced to do things they would not like to do and feel like they have no right to make decisions about their body and health. Furthermore, with the government's interference in women's reproductive healthcare, women's personal autonomy over their bodies is even more limited, impacting many different aspects of their lives, such as their sex lives (e.g., limit or abstain from sex, add or change birth control methods). A participant stated “I would have issues taking part in any sexual activities because out of fear getting pregnant because in case I do it, I will be forced to carry a baby that I'm not willing to carry"; while another participant noted that it "is going to impact my sex life in that I will be forced to be on contraceptives and yeah, I would have issues taking part in any sexual activities". Having to alter or adjust to a new sex life has made participants feel like they have had to change or "sacrifice" different aspects of who they are or what they do. In addition, participants noted that their change in sexual behavior is impacting their partners as well. For example, one participant described their change in sexual behavior as not being fair to their partner, saying "it causes me anxiety to where I can't, to where I don't want to have sex with my husband, and that's not fair to him". Another participant described their feelings about how they fear their change in sex life has impacted their partner stating the following:

> Like I mentioned before, I've been super scared of, you know, having sex with my husband, and I just, I don't know he understands. I don't know to what extent or there has been no force or change of attitude from him because he's seen what I pass through whenever this hard condition became so worse and he truly understands that yes, I want us to have a baby together but my body is not physically able to do this.

Although in the quote above, the participant describes that they believe their spouse is supportive, they are still worried about what their spouse thinks of the new change in their relationship and are concerned they do not understand. Before the policy change, they already had little choice and control over their bodies and now they feel like they have had one choice and decision stripped from them. Participants are worried about their future and how they would feel if they were to become pregnant. Participants stated the following:

> It's like I'm going to have to give up my life if I am going to bring in another life here, so I feel not so ready to do that. I just have to sacrifice my life at some point.
>
> I'm trying to say is there are so many limitations in my life, that the fact that Roe v. Wade is gone, and that is such a crucial aspect of my healthcare, that if I have a life or death situation, or even if it's not a life or death situation, I suddenly have a choice, I have six weeks to decide, do I want to raise a child for the rest of their life, and essentially give up my identity in my life and sacrifice more of my health.

The above quotes, touch on how participants feel like pregnancy or raising a child would take an aspect or piece of their identity which they feel is already limited due to living with a CHC. Having personal autonomy, agency and a sense of identity makes one feel a sense of freedom in the world, but participants described they are “being denied the freedom of doing what I want to do”. When participants spoke about freedom, some also noted how they felt about the U.S. government's involvement in healthcare. Some participants feel that the government should not be in a position to decide if a woman can have an abortion because they do not know what women are going through, especially women with CHC. Two participants described this feeling as the following:

> I don't think the court has the right to deprive a woman of having an abortion, especially when they don't know what that woman's going through, and her pain and everything she's going through, I don't think the court has any right to deprive the deprived woman of that.
>
> I feel it affects us people with chronic health conditions, and they are not really being considerate about our condition, our existence.

Another participant spoke specifically about how they believe men should not be in the position to make choices regarding women's bodies, stating “It's very unfair of them to be the ones to decide the fate of those who are the ones carrying the body right so women should decide the fate of women, not the other way round”. Being left out of decision-making may have served as a reminder to the participants that they have little control (autonomy) and choice (agency) because of their CHC, and they must do what they are told despite how they feel or what the decision implies.

CHAPTER 5: DISCUSSION

Since the overturning of Roe v. Wade, women with CHCs have experienced challenges in their day-to-day lives brought on by the unanticipated effects of the policy change, threatening their health and well-being. This study aimed to address two gaps in research: 1) To understand the effectiveness of LCs as an intervention approach for promoting a sense of psychological empowerment and social connectedness and 2) To examine the effects of the policy overturn on the health and well-being of women with CHCs. The study's key findings emphasize that LCs as an intervention approach can enhance an individual's sense of psychological empowerment and social connectedness to others. Additionally, the findings highlight how the overturn of Roe v. Wade has impacted the health and well-being of women with CHCs in four ways: limited access to reproductive healthcare, reduced mental health, exacerbated health inequities, and decreased agency and autonomy.

This study advances research about LCs while also providing important insights about women's experiences per the recent overturn of Roe v. Wade which can inform future research and policy. Specifically, the study adds to the limited research about LCs and uniquely demonstrates the utility of LCs in virtual settings. The increase in participants' scores after merely one LC session suggests that even a low dose of LCs can serve as a low-cost, health intervention for individuals with CHCs, including marginalized persons experiencing low feelings of autonomy, agency, psychological empowerment, and social connectedness. Lastly, this study adds to the research on women with CHCs of reproductive age by illuminating their day-to-day experiences and highlighting the unanticipated effects of policy change. Specifically, the research findings highlight how policy change can exacerbate health inequities - calling to action a need for policy and research that considers the benefits of using a reproductive justice framework. This contribution will help policymakers as they approach future policy discussions on the RSH of women.

5.1 RQ#1 Implications Of Findings

5.1.1 Participant Gains In Social Connectedness

This study's pre and post-test survey scores revealed that LCs can effectively increase one's sense of social connectedness among women with CHCs. Various research studies also reinforce the effectiveness of LCs in that participants have reported that they found the intervention to increase their sense of “closeness” and feeling of “togetherness” due to the circle structure (Ziabakhsh et al., 2016, p. 823). LCs allow participants to collectively come together, providing a safe space that helps foster open and honest listening and sharing (Boyes-Watson, 2005). Additionally, LCs can assist individuals in coping with CHCs. For example, researchers implemented LCs to improve health outcomes for participants with type 2 diabetes (Wilken & Nunn, 2017). The author's results demonstrated that LCs promote a sense of connection, peer support, and community among the participants. Similarly, during the present study’s member reflection sessions, participants noted that they enjoyed participating in the LC because they felt connected as a group and it allowed them to be part of a small “community”; participants expressed interest in participating in a listening circle-style group regularly.

Previous research by Ziabakhsh et al. (2016) in which participants reported increased feelings of connection, support, and community entailed LCs for two hours over eight weeks. In the current study, an increase in social connectedness was evident with only one 75-minute LC, suggesting that smaller doses of LC sessions can also be effective for strengthening social connectedness. The sustainability of social gains from LC sessions is yet to be examined and is important for future research on the longer-term effectiveness of LCs.

Some participants spoke about feeling lonely or isolated because their CHC often determines what they can and cannot do which could mean spending more time indoors and alone rather than socializing. Long-term social isolation can worsen one's mental health; therefore, having the ability to be a part of a support group, such as LCs could provide immediate feelings of connection, improving their long-term health and well-being (Herrara et al., 2021; Mehl-Madrona & Mainguy, 2014; W.K. Kellogg Foundation, 2018). This is consistent with previous research studies, noting that LCs could fill gaps in mental health services and be used as a culturally appropriate mental health service, similar to group counseling (Mehl-Madrona & Mainguy, 2014). Moreover, other research findings indicated that LCs were a therapeutic intervention for women to discuss possible mechanisms of resilience and psychosocial stressors concerning pregnancy and child-rearing. The authors' results noted the LCs promoted resiliency due to the other participants validating their experiences (Abbott et al., 2022). Considering the benefits of LCs for women in the context of pregnancy, LCs could potentially serve as a useful intervention for women going through unwanted or unplanned pregnancies.

Furthermore, a surprising observation of participants' behavior during the LCs was their use of “we” and “us” language, despite the session guidelines presented to them by the facilitator asking them to use “I” or “me” language only. Participants' mixed use of both first-person and third-person accounts when answering questions could imply that they felt a greater sense of social connectedness to the women in the LC, resulting in different perspectives used in their responses. This interpretation is also consistent with participants' comments made about them empathizing with other women after the overturn and with the comments made about how they believe women need to come together.

5.1.2 Participant Gains In Psychological Empowerment

In the present study, participants were asked questions that encouraged them to open up about their day-to-day experiences living with a CHCs and to discuss how the overturn of Roe v. Wade has impacted them, allowing them to share their narratives and learn of the personal experiences of the other participants (resources). The welcoming environment created by the LC structure and guiding principles gave the participants space to add their perspectives about the socially constructed narrative or perception of women with CHCs. Participants' increased scores in their feeling of psychological empowerment were likely due in part to their having a safe space to share their personal health experiences. LCs are often described as a space where individuals can be vulnerable and form a trusting bond within the group, leading to increased feelings of psychological empowerment (Brown & Lalla, 2020). A key indicator of psychological empowerment is the ability to identify resources through shared experiences. Society has continued to lean into the idea that women with CHCs are individuals who do not take care of themselves; thus, they are the reason to blame for their health conditions, ignoring possible reasons that are outside of one's control (e.g., genetics or environmental exposures) and labeling them as incompetent and subordinate individuals (Shelton et al., 2022; Verbiest et al., 2022). Because participants were presented with the opportunity to be a part of an LC with other women with CHCs, they were able to reclaim the power that society has taken from them, sharing their experiences and correcting any pre-existing narratives that have been forced upon them, and increasing their psychological empowerment (Rappaport, 1995). The significant increase in participants' scores between their pre and post-test of the psychological empowerment scale subdomain of power-powerlessness further adds to this implication (see Table 4).

Empowerment Theory posits that empowerment occurs on three levels, individual, organizational, and community levels, and empowerment involves both processes (actions to gain control and acquire resources) and outcomes (effects or results of the process) (Zimmerman, 2012). The process and outcomes occur at more than one level of analysis (individual, organizational, and community) and influence other levels (Zimmerman, 2012). Meaning, that the processes of one level can influence the outcomes on another level (e.g., individual-level processes can lead to community-level outcomes) (Zimmerman, 2012). The current study focused on the individual (psychological) level of empowerment by having participants participate in an LC (process), which resulted in achieving psychological empowerment (outcome). Near the end of the LCs, participants were asked to share any additional thoughts. Many participants shared how they would like "a group like this to decide the fate of women, not the people who did decide it" and "would definitely advocate for maybe policies that prioritize autonomy and health". While another participant stated:

> Women with women for women is really, really important, and I believe that we women should try to get Roe versus Wade reinstated. Why do we have to sit there and just take it and just be like, oh, it's just over with or whatever? If they fought as many years as they did to get it overturned, why can't we fight it to get reinstated and have it back the way that it used to be?

The participant's quotes above signify the potential for these women to advocate or engage in community-level processes of empowerment. The significant increase in participants' scores on the psychological empowerment scale subdomain of community activism and autonomy provides additional support for this potential (see Table 4). This implication is also consistent with past research findings. For instance, the W.K. Kellogg Foundation (2017) uses racial healing circles (based on the LC structure) to provide space for individuals to discuss their experiences with racism and the history of race and racism to ultimately help with racial healing. After participating in the racial healing circle, individuals felt encouraged to take action in their communities because they felt empowered by their participation (W.K. Kellogg Foundation, 2017). Along with LCs encouraging individuals to share their stories, power dynamics are evenly distributed among participants. Each participant is given an equal opportunity to answer each question, eliminating a hierarchy effect on participation, building a sense of trust among participants and the circle facilitator, and creating an environment for individuals to connect and feel empowered (Brown & Lalla, 2020; Rappaport, 1995). Moreover, Brown and Lalla (2020) also highlight LC as values-based and a relational process, allowing a healing process among individuals and communities and building a foundation for social justice and positive change to manifest. Considering the comments made by participants in the present study and past literature suggesting LC may empower individuals to engage in social change, future research is warranted on the effect of LCs on increasing organizational and community-level empowerment.

5.1.3 Listening Circles As A Health Intervention

The significance of the benefits of LCs in increasing one's sense of social connectedness and psychological empowerment is important when considering the health inequities created by the relation of the intersection of race, class, gender, and ability. Women with CHCs are more vulnerable to feeling a low sense of social connectedness and psychological empowerment due to the effects of living with their CHC, such as feeling isolated due to their CHC limiting their ability to leave their home or feeling disempowered due to their disproportionate treatment from their healthcare provider (Hassan et al., 2023b). However, these effects are exacerbated for LIEM; specifically Black women. Compared to other racial and ethnic groups, Black Americans are more prone to developing early-onset CHCs and have higher rates of mortality. These rates have worsened over time specifically for Black women (Simons et al., 2021). Due to the compounding effects of sexism, classism, and racism experienced by Black women in the U.S., Black women with CHCs are at greater risk of experiencing lower rates of social connectedness and psychological empowerment.

Given the research findings indicating LCs can increase one's sense of social connectedness and psychological empowerment, and considering the larger percentage of the study's sample being BIPOC women, LCs could benefit marginalized groups particularly. This aligns with previous research studies using the LC structure as a health intervention, indicating that LCs can be considered both a culturally competent intervention and a woman-centered intervention due to the circle structure. A culturally competent and women-centered intervention accounts for individual differences by considering and integrating different aspects of the individuals participating in the LC (Schumacher, 2014; Ziabakhsh et al., 2016). For example, considering one's racial culture makes the intervention more accessible and effective for racial and ethnic minorities. The current study used an online platform to increase the accessibility of the study to a greater number of participants who may not be able to travel due to financial restraints or due to restraints caused by their CHC (ie., limited mobility). Virtual LC sessions may be particularly beneficial for low-resourced populations.

Research by Brown and Lalla (2019) indicated that women-centered interventions increase the applicability and usefulness of data because the interventions consider individual differences. By doing so, researchers can interpret and disseminate research findings accurately, increasing the amount of knowledge of the truthful experience of women with CHCs. This is important for women with CHCs, given there is limited research on the current study sample, LIEM women of reproductive age with CHC. Moreover, due to LCs encouraging individuals to share their experiences, knowledge is also shared between the LC participants. For women with CHC, this could serve to be beneficial because they can share information including how to manage specific CHCs effectively. Because women with CHCs could address their concerns and resolve stress-related problems caused by their CHCs, LCs could reduce the number of visits to hospitals, public health clinics, emergency rooms, and other health services. This is important considering the financial toll of living with a CHC due to the expenses paid on medication, doctor visits, and lifestyle changes (Miller, 2022). Due to previous literature highlighting LC benefits which include: culturally competent and woman-centered intervention, low cost, increased intervention effectiveness for participants, and increased dissemination of accurate experiences and the current study findings of LC increasing one's sense of social connectedness and psychological empowerment scores, LCs could serve as a particularly valuable health intervention for marginalized women such as Black women with CHCs.

5.2 RQ#2 Implication Of The Findings

5.2.1 Limited Access To Reproductive Healthcare

Access to comprehensive healthcare, including RSH and treatment and services for CHCs is a basic human right (United Nations Human Rights Office of The High Commissioner, n.d.). However, with the overturn of Roe v. Wade, women with CHCs are experiencing difficulty accessing needed services, which poses a risk to their short and long-term health and well-being. During the LC, participants expressed that abortion access is a vital component of their RSH because it can be used as a life-saving measure, or used as an option to make the best health-informed decision. These results are consistent with past research claiming pregnancy for women with CHCs is complex because their treatment may interfere with a successful pregnancy (e.g., their treatment has teratogenic effects threatening the well-being of the fetus) or it could worsen underlying conditions (Hassan et al., 2023). With the overturn, women with CHCs have to make a crucial decision to either stop their treatment and risk their health worsening, try a new treatment and risk it not being as effective, or receive an abortion to protect their health. Carrying a child to term poses numerous health risks for some women with CHCs, such as increased risk of miscarriage, hyperemesis gravidarum, preeclampsia, gestational diabetes, preterm labor, infections, depression or anxiety, fetal death, stillbirth, and ectopic pregnancies (Berg & Woods, 2023; Cleveland Clinic, 2022).

Moreover, some participants noted that they are not only being denied access to abortion procedures but the overturn has also made accessing treatment for their CHC more difficult, including medication prices increasing and having pharmacists asking about their pregnancy status before distributing prescriptions. When considering the demographic characteristics (see Table 1 and Figure 1) of the study participants (i.e., LIEM and living in the Southern Atlantic region of the U.S.) and their responses to the questions asking the extent the overturning has impacted them in the screener questions (see Table 2), their comments were not surprising. The southern region of the U.S. has the highest number of individuals with CHCs and higher rates of poverty (Osae et al., 2018). Additionally, the southernmost states have the strictest abortion bans and restrictions (see Appendix H), restricting access to abortion pills such as Methotrexate or Misoprostol which are used to treat autoimmune diseases, and certain cancers (Byron et al., 2022; Heath, 2022; Sangtani et al., 2023; Tanne, 2022). Taken together, the findings indicate that the new barriers women are facing are threatening their ability to receive comprehensive healthcare, posing a risk to their health and well-being, and denying them their basic human rights (Centers for Disease Control and Prevention, n.d.; Tanne, 2022; United Nations Human Rights Office of The High Commissioner, n.d.; Verbeist et al., 2022).

Although the overturn of Roe v. Wade has limited access to abortion services and consequently limited some preventive care services, women may have other resources and options they can use to help them cope with the policy change, learn about the abortion laws of each state, and learn more about where to access abortion services. For instance, some states do not have strict abortion bans, including states in the South Atlantic region of the U.S.; the region where the study participants are geographically located. The specific states of the South Atlantic region with more flexible and lenient abortion restrictions include Delaware, Virginia, Maryland, and the District of Columbia (see Appendix H). If women are looking to access abortion services, non-profits (e.g., Planned Parenthood, National Network of Abortion Funds, National Abortion Federation) have resources on their websites that outline how to find funding for abortion services, where to access abortion services, and what to know about the abortion laws in each state. Additionally, women can advocate for abortion access by voting in local, state, and federal elections. Furthermore, there are support groups for women on social media platforms, including Facebook and Reddit that present individuals with a safe and supporting place to share opinions, offer support, and exchange experiences, allowing them to process events such as the overturn of Roe v. Wade or living with a CHC.

5.2.2 Navigating New Uncertainties Is Psychologically Draining

With the overturn of Roe v. Wade, new abortion bans and restrictions are changing frequently in the U.S. (Byron et al., 2022; Sangtani et al., 2023; Tanne, 2022). Because abortion laws and policies are constantly changing by state, women are having to deal with the persistent uncertainties and unknowns, causing unwanted stress. A major theme generated from participant discussion in the LC included the psychological toll of dealing with constant uncertainties caused by the change in policy of Roe v. Wade. Individuals who live with CHCs already experience varying levels of uncertainty due to the effects of living with a CHC. Uncertainties may be caused by an individual's unknowingness of the condition's progression, lack of knowledge on how to effectively treat or manage their CHC, or the unpredictableness of their CHC symptoms. With the added layer of doubt caused by the change in laws and policies, women with CHCs are dealing with more uncertainties than before the overturn of Roe v. Wade. Living with higher levels of uncertainty is associated with higher levels of stress or depressive symptoms which are associated with social isolation, guilt, and low quality of life (Brown et al., 2020; Herrara et al., 2021). Participants explained that the policy change itself was anxiety-inducing because of its implications and how it would affect women. One interpretation of these findings is that participants knew abortions were now going to be more difficult to access while empathizing with other women across the U.S. made participants stressed; consequently, worsening any anxiety they already experienced due to their CHC. Added stress can affect CHC treatment and management efficiency and one's long-term health (Herrara et al., 2021). For example, dealing with additional stress could increase one's blood pressure, causing concern for individuals with pre-existing conditions of hypertension.

Additionally, women in the current study reported that they are fearful due to the uncertainty surrounding the legal consequences of abortion services and the possibility of becoming pregnant. As laws and policies change in states across the U.S., women and healthcare providers face possible legal consequences. However, the laws vary across each state, causing confusion and more uncertainty. It should be noted that the states with the most legal consequences put into place are located in the south (see Appendix H) which has a higher number of vulnerable populations (e.g., women with CHCs), notably where the majority of the study sample (see Figure 1) is geographically located (Byron et al., 2022; Sangtani et al., 2023). Moreover, if an individual does break a law they will face financial repercussions, threatening the financial stability of women across the U.S. For women already facing financial instability, such as women with CHCs, breaking the law by having an abortion or receiving other abortion-related services poses a greater threat to their well-being. Living with a CHC is already financially taxing; thus, adding on the legal repercussions of breaking the law could limit their ability to afford needed treatment and management (Miller, 2022).

Also, women indicated that they are fearful of becoming pregnant because it could impact their relationships with their partners and family, cause further financial instability, or threaten their CHC treatment. Participants said “It has made many people become, let me say, financially unstable” while another participant said, “It will be a burden to everyone around me, especially if we are not we are not financially capable”. These findings highlight how the uncertainty of legal consequences and the uncertainty of becoming pregnant both come with financial consequences that women with CHCs are fearful of, increasing their stress and worsening their health. These implications align with past research findings on the mental health and financial consequences of being denied an abortion and having an unwanted pregnancy (Coates et al., 2024; Londoño Tobón et al., 2023). People denied abortions tend to have worsened financial, social, and health outcomes, and these effects tend to affect their families as well (Londoño Tobón et al., 2023). Carrying a child requires a long-term investment that requires mothers and families to sacrifice their time, financial stability, and emotional labor (Coates et al., 2024; Londoño Tobón et al., 2023). However, these investments and sacrifices are not attainable for everyone, such as some women with CHCs due to the compounding effects of caring for a child and living with their CHC (e.g., the physical toll on their bodies and the additional emotional distress). In addition, the mental health effects of being denied an abortion also affect the well-being and welfare of the child. Previous research findings have demonstrated that children of those denied abortions are at risk for significant negative long-term psychosocial outcomes. Additionally, the increased stress of raising a child from an unwanted pregnancy increases the likelihood of possible child maltreatment (Coates et al., 2024; Londoño Tobón et al., 2023). Given the possible negative effects on children born from unwanted pregnancies, further research is warranted to better understand how the policy change is affecting families in addition to the woman denied an abortion.

Participants also reported fearing pregnancy because they may have to change, delay, stop, or continue treatment despite the risks (e.g., preterm birth or miscarriage). This is consistent with literature that describes some CHC treatments that complicate pregnancy, posing a risk to both the mother and fetus (Hassan et al., 2023a; Suran, 2022). On top of the risk associated with pregnancy and CHCs, being denied an abortion or carrying a child one did not wish to have is associated with pre-eclampsia, postpartum hemorrhage, chronic pain, and overall worsened health, persisting past pregnancy and causing significant, long-term health consequences (Coates et al., 2024; Londoño Tobón et al., 2023). Therefore, the health risks associated with pregnancy, CHCs, and being denied an abortion, pose a significant concern for women with CHC who have limited access to abortion services.

Furthermore, there is a mental health gap in the U.S. due to an increase in psychiatric demands and a decrease in mental health workers (Londoño Tobón et al., 2023). Training in the management of mental health disorders during and after pregnancy was and has continued to be limited for mental health professionals, a detriment to the mental health of women denied an abortion and forced to carry an unwanted child. Moreover, cognitive and behavioral health efforts and services are unequally distributed, making it more difficult for LIEM women to access them (Van Wilder et al., 2021). This is particularly concerning given the significant mental health concerns described by the current study's participants and the concern for the mental health of women who are denied abortions (Londoño Tobón et al., 2023). Whereas past researchers have found that women being denied an abortion is anxiety-inducing (Miller, 2022), the present study identified other layers of uncertainties and unknowns that are mentally distressing, causing significant concern for the long-term health and quality of life of women with CHC, their families, and children. Further research is warranted on the mental health effects of the policy change on women with CHC.

5.2.3 Experiencing Exacerbated Health Inequities

The results of the present study indicated that the overturn of Roe v. Wade has exacerbated health inequities; specifically, for Black women. Participants explained that they already experience disproportionate healthcare access and quality due to barriers created by the intersection of race, gender, socioeconomic status, geographic location, and ability, and the overturn has created more barriers due to the increase in strict laws and policies (Haggerty et al., 2020).

The majority of the study sample included Black/African American women (75.8%, *n* = 25); surprisingly, only a few participants explicitly spoke of their experiences being Black women during the LCs. However, when this theme was shared with participants during the member reflection sessions, participants shared that the theme resonated the most with them, reflecting on their experiences and opinions on the systemic racial injustices Black women face in their day-to-day lives. These findings mirror previous research, highlighting the U.S.

persistent systemic and structural racism in the healthcare system that is enabled by social norms and unjust policies and practices (Beck et al., 2024; Berg & Woods, 2023). Martin et al. (2023) found that 21% of adults in the U.S. have experienced discrimination in the healthcare setting, noting racial discrimination as the most common form of discriminatory experiences. During the LC, Black women described dealing with racial discrimination from their healthcare providers as “mentally exhausting” and they often have a burdensome time getting their doctors to understand and listen to them as Black women with CHCs. With the policy change, participants said they fear their experiences may worsen by adding a conversation about pregnancy or abortion access. Specifically, participants noted they believed the conversations would become more complex and they would prefer to avoid the conversations if possible. Over time, these negative experiences can lead to a loss of autonomy and self-determination (Afulani et al., 2022; Altman et al., 2019). Participants expressed concerns and fears add to the growing evidence that suggests that ongoing issues, such as disrespect and discrimination within the healthcare system affect the accessibility of care and experiences of BIPOC individuals in the context of pregnancy (during pregnancy, during birth, and after delivery) (Altman et al., 2019). Considering the new healthcare landscape of limited abortion access across the U.S., there is a growing concern for the health outcomes of the mother and child of an unwanted or unintended pregnancy (Coates et al., 2021). Additionally, participants' discussion about their mentally distressing treatment with medical providers provides further evidence of how racial discrimination is “characterized as an uncontrollable environmental stressor” that can worsen mental health outcomes (Brownlow et al., p.11, 2019; Simons et al., 2021). Given the significant impact the policy change has had on Black women's mental health there is a concern for Black women with CHCs because they are at a greater risk of experiencing mental distress due to living with their CHC.

Furthermore, participants expressed that before the overturn of Roe v. Wade, they experienced difficulties accessing abortion services and accessing their needed CHC treatment and services. Black women experience disproportionate barriers to accessing quality healthcare, such as the ability to pay for their healthcare treatment and services, knowledge of their different healthcare options, and transportation access (Coates et al., 2024; Davidson, 2019; Sutton et al., 2021). With the policy change, access to healthcare treatment and services has become an even greater issue, causing concern for the continuation of the CHC treatment and management and long-term health outcomes; specifically for LIEM women. Approximately 10% of Americans are uninsured, with the population most uninsured being LIEM individuals living in rural, southern areas (Osae et al., 2018). Individuals living in rural, southern areas experience greater unemployment rates and are less likely to have access to medical services (e.g., pharmacies). Compared to white women, Black women are underinsured and are more likely to live in rural, southern areas, limiting both their access to needed treatment for their CHC and contraceptives. Because of the disproportionate access and opportunity to equitable health care and treatment, more Black women are unable to properly manage and care for their CHCs and they are more likely to have unintended pregnancies compared to other races (Osae et al., 2018; Sutton et al., 2021). This is significant because the overturn of Roe v. Wade has restricted abortion access in states with high rates of poverty. Therefore, disproportionately impacting LIEM women, such as Black women with CHCs who have higher rates of mortality and pregnancy complications. Taking into account the risks associated with living with a CHC and the limited access to abortion services, LIEM Black women have an increased risk of maternal mortality, preterm births, postpartum depression (PPD), pre-eclampsia, hemorrhaging, and worsening underlying health conditions (Cleveland Clinic, n.d.). Participants' discussion of the policy change adding an extra barrier to receiving equitable healthcare treatment reflects the evidenced impact of how policy change can disproportionately impact individuals and exacerbate health inequities. Specifically, participants' comments concerning the overturn of Roe v. Wade extends our knowledge and provides additional support for the idea that the overturn has disproportionately affected the health and well-being of Black women with CHCs.

Taking into consideration previous literature on the U.S. healthcare system's long history of systemic and structural racism impacting Black women's access to equitable healthcare, the current study findings reflect how the policy change served as another demonstration of how the U.S. continues to not prioritize or consider the lives of marginalized individuals. Therefore, future policy change must take a reproductive justice framework rather than a reproductive rights framework and a “pro-choice” lens.

The reproductive justice movement began in the U.S. in the 1990s, and the reproductive justice framework combines reproductive rights and social justice and originated as a critique of “mainstream” white feminism (Morison, 2020; Ross, 2017). The reproductive justice movement sought to bring attention to the challenges women of color experience because women's experiences were continuing to be grouped as singular, homogenous experiences and concerns, predominantly representing white, middle-class women's values and experiences (e.g., abortion and contraceptive rights) (Morison, 2020; Ross & Solinger, 2017). Therefore, the reproductive justice movement sought to bring light to the experiences of the women often excluded, including Black women and other women of color. Throughout history, marginalized women have been deemed as “less-than” or “unfit”, resulting in practices such as forced sterilization and contraceptive coercion, taking away their right to reproduction and parenthood. For marginalized women, reproductive justice was about more than abortion or contraceptive access, it also included the right to reproduction and parenthood (Morison, 2020; Ross et al., 2017; Ross & Solinger, 2017).

Furthermore, the use of an individual's right to "choice" discourse overlooks that rights and choice are often denied to marginalized individuals, and "any movement based primarily on the right to choice thus favors predominantly white middle‑class women who can make reproductive decisions more easily than poor or low‑income women and women of color, whose options are limited by their social location" (Chinn et al., 2021; Morison, 2020, p.2; Ross et al., 2017). Using a reproductive justice framework for policy-making decisions is more inclusive because it focuses on "the human right to make personal decisions about one's life, and the obligation of government and society to ensure that the conditions are suitable for implementing one's decisions" (Morison, 2020, p. 2; Ross, 2017, p.174). Thus, a reproductive justice framework would consider the experiences and concerns of all women, including women with CHCs because it would address larger systemic and structural issues of power and control, addressing the unanticipated effects of policy change, such as the ones from the overturn of Roe v. Wade (Chinn et al., 2021).

5.2.4 Decreased Agency And Autonomy

The findings also highlight how the overturn of Roe v. Wade is jeopardizing different aspects of the agency and autonomy of women with CHCs. When talking about autonomy, participants spoke about the significance of their CHC taking away parts of their bodily autonomy because their condition often dictates what they can or cannot do. For example, having to change their diet, change the amount and type of physical activity, reduce the amount of socialization with others, and limit the number of physical activities that may induce stress. The overturn of Roe v. Wade added an additional external influence (i.e., the government), interfering with their control over their reproductive health and consequently, worsening women with CHC's sense of reproductive autonomy and restricting their ability to act freely (agency).

In addition, participants spoke of having to change aspects of their contraceptive methods. However, not all contraceptives are readily available to all women due to price, or they cannot use them due to pre-existing conditions. For instance, not all hormone-based contraceptives are recommended due to their interference with CHCs, such as hypertension, and adverse effects, including increased risk of immunology disorders and female sexual dysfunction (Segarra et al., 2023). Given the adverse effects and interferences with CHCs, abortions may be the only form of contraception that a woman with a CHC has. Also, participants explained that they have had to change other aspects of their sex lives, including limiting or abstaining from sex. Participants modifying their behavior reflects the direct influence the policy change has had on women's reproductive autonomy, inevitably impacting their sexual autonomy and agency. Sexual autonomy "allows women to navigate sexual experiences, recognize their sexual feelings as distinct from societal pressures and desires, and exercise control in their own sexual decision-making" and is critical in a woman's healthy sexual development (Willie et al., p.1, 2023; Schalet, 2011). Also, a sense of sexual autonomy plays a crucial role in reducing the risk of negative sexual and reproductive health outcomes (Dodoo et al., 2019; Willie et al., 2023). Sexual agency is best described as an "individual's effort to shape their immediate experiences or longer courses of life through sexuality" (Bay-Cheng, 2019; Willie et al., 2023, p.2). Women's decrease in sexual autonomy and agency is also impacting their relationships with their partners. Participants discussed that limiting or abstaining from sex has made communicating with their partners more difficult and they feel guilty for how their behavior change is affecting their relationship. Future research should expand on the policy changes' effect on romantic and sexual relationships, focusing on the types of conversations individuals are having with their partners.

The U.S. government and healthcare system have a history of undermining women with CHCs by taking their power and control from them, rarely prioritizing their reproductive and sexual autonomy due to social norms, biases, and prejudice against these women. As a result, women with CHCs are painted in society as less than compared to other women because they have a CHC. Because of this projection, their opinions are not considered and are left out of decisions on policy change, such as the overturn of Roe v. Wade. Many participants reported that being left out of decision-making about their bodies and policy makes them feel like their lives are constantly looked over and their health is not important. As a result, the overturning serves as a reminder of how little autonomy or choice they have. Having full reproductive and sexual autonomy and agency is important in promoting women's empowerment which is essential to their overall well-being (Dodoo et al., 2019). This is consistent with previous research demonstrating that when a woman's autonomy is not recognized and they are unable to act freely, their sense of empowerment is threatened (Hassan et al., 2023b; Nieuwenhuijze & Leahy-Warren, 2019). For this reason, finding ways to increase one sense of empowerment is necessary (Miller, 2022).

Furthermore, states with the strictest abortion bans and restrictions are also the states (e.g., Tennessee) introducing laws that attack the bodily autonomy of the LGBTQ+ community; therefore, the overturning of Roe v. Wade could be described as the start of a domino effect, targeting all aspects of bodily autonomy and agency (Beck et al., 2024; Hassan et al., 2023b; Nieuwenhuijze & Leahy-Warren, 2019). Because of this possible implication, future research is warranted on the unanticipated effects of the overturn on other marginalized groups, such as the

LGBTQ+. For women and society, the U.S. has taken a large step backward in protecting all aspects of women's autonomy and agency, by removing a “national safeguard”, and erasing the hard work done by reproductive and sexual health advocates throughout history (Beck et al., 2024).

5.3 Limitations And Future Research

Although the present study findings support the hypothesis that LCs increase an individual's level of psychological empowerment and social connectedness, it is appropriate to recognize potential limitations. Traditionally, LCs take place in person rather than online; however, the present study used the outline platform Zoom (Boyes-Watson, 2005; Indigenous Education, n.d.; W.K. Kellogg Foundation, 2017). Participants experienced difficulties hearing instructions and remembering when it was their time to speak which occasionally disrupted the flow of LC sessions. The communication issues were likely due to their Wi-Fi connection - a challenge unique to online LCs. Despite the challenges of using an online platform, the present study builds on LC research by expanding the use of LCs to online settings. Given participants' increase in psychological empowerment and social connectedness after one LC, future research should consider holding multiple online LC sessions to see if there is a greater effect between participants' pre-test and post-test scores. Also, future research should expand on the benefits of online platforms while determining protocols and ways to avoid online challenges, ensuring maximum efficiency and effectiveness for participants. Protocols could include having a timer visible on the screen during the LC for participants to see. By doing so, participants will be able to keep track of how much time they have left to answer questions during the LC. Also, future protocols could include having researchers share the instructions via email before the session begins, encouraging them to come to the session with pre-identified questions about the instructions. Sharing instructions in advance will help ensure all participants know what the expectations are of the LC and reduce the amount of time spent reviewing instructions.

Another notable limitation includes the varied sizes of the LCs. The minimum number of participants per LC was three while the maximum was eight participants. Due to the varied size of participants per LC session, some participants in larger groups may have not felt the effects of the LC benefit social connectedness to the greatest extent, impacting their post-test scores. If participants were in a circle with fewer participants, they may have not felt as socially connected or psychologically empowered. Potential future studies should examine the impact of group size to better understand the most optimal group characteristics between LC participation and social connectedness and psychological empowerment.

Participants from the current study had multiple different types of CHCs, strengthening the study's findings because it opened up participant eligibility and widened the type of experiences shared during the LCs. However, not all CHCs are represented in the study's sample, and some CHCs are more represented than others. Among participants, 45.5% (*n* =15) of the participants indicated they had chronic diabetes, therefore a significant amount of what was shared during the LCs represent the experiences of women with chronic diabetes. Due to this, the research findings may not appeal to women with different CHCs because the policy change may be impacting them differently. In spite of this limitation, the disproportionate representation of CHCs could demonstrate that the overturn has had varying effects on women depending on what CHC they have. Future researchers should consider delving deeper into the lived experiences of women with chronic diabetes to fully understand the policy changes' effect on their health and well-being. Additionally, to further understand the unanticipated effects of the overturn on women with CHCs, future research should focus on ensuring their sample represents the experiences of multiple CHCs equally.

The present study participants were from the South Atlantic region of the U.S., limiting the type of voices and experiences shared to one region of the U.S. However, not all nine states of the South Atlantic region were represented in the study's sample. No participants were from South Carolina, thus the experiences participants shared during the LC may not resonate with individuals from all states in the South Atlantic region of the U.S. Moreover, the geographic location of participants is important because abortion bans and restrictions vary by state, with the strictest bans and restrictions being in the south (Byron et al., 2022; Sangtani et al., 2023). Although the study participants were from varying states with different levels of abortion bans and restrictions, a significant number of participants were from more conservative states with greater restrictions. Therefore, these findings may not represent individuals who live in states with more liberal politics and expanded abortion access. Despite this limitation, a strength of the study is that it sheds light on the experiences of individuals living in the South Atlantic region with strict abortion bans.

In addition, the current study results do not represent women of all races or individuals with varying income, given the majority of the women in the sample identified as Black/African American and all had a yearly income less than or equal to $31,402. Although this limits the type of voices illuminated and experiences shared, it does shed light on the disproportionate effects of the overturn of Roe v. Wade on LIEM, particularly Black women. Future researchers should include additional recruitment strategies to ensure their sample is more diverse. By doing so, more women with CHCs will have the opportunity to share their day-to-day experiences, increasing the possibility of them feeling a sense of psychological empowerment. Furthermore, ensuring the study's sample is more diverse will provide a clearer understanding of how the policy change impacted women with CHCs, making the implications of the findings more applicable to all women with CHC.

CHAPTER 6: CONCLUSIONS

As the second anniversary of the overturn of Roe v. Wade has passed, we are still coping with the magnitude of the effects of the policy change. The study findings contribute to the limited research on the unanticipated effects of the overturn of Roe v. Wade, illuminating the experiences of women with CHCs. The policy change exacerbated health inequities experienced by women with CHCs, increasing barriers to receiving reproductive healthcare, worsening mental health, and stripping them of bodily autonomy and agency. However, the unanticipated effects are exacerbated for Black women due to persistent systemic and structural racism in the U.S. healthcare system. Determining woman-centered and culturally competent ways to increase women with CHCs' sense of psychological empowerment and social connectedness is critical as policy rapidly changes across the U.S. Interventions, such as LCs can be used as a low-cost health intervention for marginalized persons experiencing low feelings of psychological empowerment and social connectedness. To further understand the policy changes' direct and indirect impact on these individuals' health and well-being, future policy and research must consider the benefits of using a reproductive justice framework. This contribution will help policymakers as they approach future policy discussions on the RSH of women. Such action is critical to understanding the unanticipated effects of the policy change on all women and how the U.S. continues to exert power and control over women's bodies by making the body political.

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Appendix A

Screener Survey Questions

The layout and sequence presented here mirror the flow of the Qualtrics survey, ensuring that the structure and progression of the questions remain consistent with how they were administered online.

Screener Questions

separate screen

The purpose of this study is to understand how the overturning of Roe v. Wade has impacted women with chronic conditions' health and well-being and to test the effectiveness of an intervention called listening circles. Participants will be asked to share their experiences living with chronic conditions while participating in a listening circle with others. If you are interested in learning more about the study and participating, please, begin the survey and answer the screener questions below. The screener questionnaire will ask questions about your sex, age, chronic conditions, residency, internet accessibility, income, and the impact of Roe v. Wade on your health and well-being.

This research is led by UNC Charlotte. Your participation in this research study is completely voluntary, and you may withdraw at any time. All data collected from this study will remain confidential.

1. Which sex do you most identify with?
    a. Woman*
    b. Other*

for anyone who chooses answer B

"Thank you for your interest in participating in this research study. At this time, you do not qualify for participation. You may exit this survey by closing this screen."

for anyone who chooses answer A

2. Are you between 18 and 49 years of age?
    a. Yes*
    b. No*
        i.

for anyone who chooses answer B

"Thank you for your interest in participating in this research study. At this time, you do not qualify for participation. You may exit this survey by closing this screen."

for anyone who chooses answer A

3. Do you have one or more chronic conditions?
    a. Yes*
    b. No*

for anyone who does not choose answer B

"Thank you for your interest in participating in this research study. At this time, you do not qualify for participation. You may exit this survey by closing this screen."

for anyone who chooses answer A

4. Do you live in one of the following states: Delaware, the District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, or West Virginia?
    a. Yes
    b. No

for anyone who does not choose answer B

“Thank you for your interest in participating in this research study. At this time, you do not qualify for participation. You may exit this survey by closing this screen.”

for anyone who chooses answer A

5. Do you have access to the internet, and have a device with a working video camera? Please, note that this study does require participants to join a Zoom meeting with their cameras on.
    a. Yes
    b. No

for anyone who does not choose answer B

“Thank you for your interest in participating in this research study. At this time, you do not qualify for participation. You may exit this survey by closing this screen.”

for anyone who chooses answer A

6. Is your annual household income less than or equal to $31,402?
    a. Yes
    b. No

for anyone who does not choose answer B

“Thank you for your interest in participating in this research study. At this time, you do not qualify for participation. You may exit this survey by closing this screen.”

for anyone who chooses answer A

7. Has the overturning of Roe v. Wade impacted your health and well-being in any way?
    a. Yes
    b. No

for anyone who does not choose answer B

“Thank you for your interest in participating in this research study. At this time, you do not qualify for participation. You may exit this survey by closing this screen.”

for anyone who does answer A they will move to the informed consent process*

Consent Process

At this time, you qualify to participate in this study. The rest of the study consists of answering additional demographic and study-related questions, completing two more surveys, and participating in an online listening circle via Zoom. The listening circle will last approximately 75 minutes.

Attached is the consent form for this study. Please review this carefully before continuing.

a PDF of the informed consent will be attached for downloadable purposes

1. To continue, please check the following boxes.

    ☐ I have read and understood the information provided above.

- ☐ I agree to participate in this study and understand I have the right to withdraw from the study at any time.
- ☐ I consent to the use of any data for research purposes.
- ☐ I consent to the audio recording of the listening circles.
- ☐ I understand that to receive compensation for participation I must provide identifiable information. This information will be kept separate from the study's data and will be deleted after compensation is distributed.
- ☐ I understand that checking the boxes in the survey and typing my name in the response box are being used as a legal digital signature.

By typing your name in the survey response box and checking the boxes listed, you are agreeing to be in this study. Make sure you understand what the study is about before you complete these actions. You will receive a copy of the informed consent document for your records.

2. I understand what the study is about and my questions so far have been answered. I agree to take part in this study. To continue, please type your name in the response box.

short answer response

separate screen

As noted in the informed consent, you will be asked to answer additional demographic and study-related questions. The next set of questions will ask you more information about your age, race, ethnicity, permanent residency, what chronic conditions you have and for how long, how the overturning of Roe v. Wade affected your health and well-being, and how you heard about this study.

Demographic questions

1. What range reflects your current age?
    a. 18-28
    b. 29-39
    c. 40-49
2. What option best describes your race? (select all that apply)
    a. Asian
    b. Black/African American
    c. Native Hawaiian
    d. Native Indian
    e. White
    f. Not listed (will have the option to type in a short answer response)
3. Do you identify as Hispanic/Latinx?
    a. Yes
    b. No
4. Please note the city and state you live in using the following format: (city, state)
5. *short answer response format*
6. ***Additional Information***
7. How long have you had your chronic condition(s)?
    a. Less than one year
    b. 1-5 years

    c. 6-10 years
    d. 11+ years

8. Please, select all chronic conditions you have from the selection below.
    a. Alzheimer's disease
    b. Cancer
    c. Cardiovascular disease
    d. Chronic kidney disease
    e. Chronic lung disease
    f. Diabetes
    g. Heart disease
    h. Hypertension
    i. Respiratory disease
    j. Stroke
    k. Other *open-ended data entry*
9. To what extent has your health care been impacted by the overturning of Roe v. Wade?
    a. [Likert/sliding scale response format]
    b. Very little extent
    c. Little extent
    d. Neutral
    e. Large extent
    f. Very large extent
10. To what extent has your chronic health condition management been impacted by the overturning of Roe v. Wade?

[Likert/sliding scale response format]

   a. Very little extent
   b. Little extent
   c. Neutral
   d. Large extent
   e. Very large extent

11. To what extent has your overall well-being been impacted by the overturning of Roe v. Wade?
    a. [Likert/sliding scale response format]
    b. Very little extent
    c. Little extent
    d. Neutral
    e. Large extent
    f. Very large extent
12. How did you hear about this study?
    a. Social Media
    b. Flyer in WIC or Family Planning Clinics
    c. Flyer in an OB-GYN office or other women's clinic
    d. Flyer near public transportation
    e. Flyer near a food pantry
    f. Word of Mouth
    g. Other *open-ended data entry*

Final Message

Please click on the link below. You will be directed to a website, SignUpGenius. Once directed to this site, you will sign up for a listening circle date.

Please click the link now to continue.

Link placeholder

Appendix B

Empowerment and Social Connectedness Pre-Test Survey

Name: Please, provide your first and last name in the response box below. Your name will not be used in any of the study's findings. Collecting this information will aid the researcher in ensuring the data being analyzed is consistent. If you have more questions, please, reference your consent form or contact the primary researcher using the following email: pdavenp1@charlotte.edu.

Introduction Statement: The purpose of this survey is to determine your current level of psychological (individual) empowerment and level of social connectedness. Please, respond with how you are ***feeling in the current moment***.

Empowerment Scale (Rogers et al., 2010)

Answer choices: 1 strongly agree; 2 agree; 3 disagree; 4 strongly disagree

1. Currently, I feel that I can pretty much determine what will happen in my life.
2. Currently, I feel that people have more power if they join together as a group.
3. Currently, I feel that getting angry about something never helps.
4. Currently, I feel that I have a positive attitude toward myself.
5. Currently, I feel that I am usually confident about the decisions I make.
6. Currently, I feel that people have no right to get angry just because they don't like something.
7. Currently, I feel that most of the misfortunes in my life were due to bad luck.
8. Currently, I feel that I see myself as a capable person.
9. Currently, I feel that making waves never gets you anywhere.
10. Currently, I feel that people working together can have an effect on their community.
11. Currently, I feel that I am often able to overcome barriers.

12. Currently, I feel that I am generally optimistic about the future.
13. Currently, I feel that when I make plans, I am almost certain to make them work.
14. Currently, I feel that usually, I feel alone.
15. Currently, I feel that experts are in the best position to decide what people should do or learn.
16. Currently, I feel that I am able to do things as well as most other people.
17. Currently, I feel that I generally accomplish what I set out to do.
18. Currently, I feel that people should try to live their lives the way they want to.
19. Currently, I feel that I feel powerless most of the time.
20. Currently, I feel that when I am unsure about something, I usually go along with the rest of the group.
21. Currently, I feel that I am a person of worth, at least on an equal basis with others.
22. Currently, I feel that people have the right to make their own decisions, even if they are bad ones.
23. Currently, I feel that I feel I have a number of good qualities.
24. Currently, I feel that very often a problem can be solved by taking action.
25. Currently, I feel that working with others in my community can help to change things for the better.

Social Connectedness (Lee and Lee, 2001)

Answer choices: 1 strongly disagree; 2 disagree; 3 somewhat disagree; 4 somewhat agree; 5 agree; 6 strongly agree)

1. Currently, I feel distant from people
2. Currently, I feel related to most people

3. Currently, I feel like an outsider
4. Currently, I see myself as a loner
5. Currently, I feel disconnected from the world around me
6. Currently, I feel that I don’t participate with anyone or any group
7. Currently, I feel close to people
8. Currently, I feel even around people I know, I don’t feel that I really belong
9. Currently, I feel like I am able to relate to my peers
10. Currently, I feel like I catch myself losing a sense of connectedness with society
11. Currently, I feel that I am able to connect with other people
12. Currently, I feel understood by the people I know
13. Currently, I see people as friendly and approachable
14. Currently, I fit in well in new situations
15. Currently, I have little sense of togetherness with my peers
16. Currently, my friends feel like family
17. Currently, I find myself actively involved in people's lives
18. Currently, even among my friends, there is no sense of brother/sisterhood
19. Currently, I am in tune with the world
20. Currently, I feel comfortable in the presence of strangers

Appendix C

Empowerment and Social Connectedness Post-Test Survey

Introduction Statement: The purpose of this survey is to determine your current level of psychological (individual) empowerment and level of social connectedness after participating in the listening circle. Please, respond with how you are ***feeling in the current moment.***

Empowerment Scale (Rogers et al., 2010)

Answer choices: 1 strongly agree; 2 agree; 3 disagree; 4 strongly disagree

1. After participating in the listening circle, I feel that I can pretty much determine what will happen in my life.
2. After participating in the listening circle, I feel that people have more power if they join together as a group.
3. After participating in the listening circle, I feel that getting angry about something never helps.
4. After participating in the listening circle, I feel that I have a positive attitude toward myself.
5. After participating in the listening circle, I feel that I am usually confident about the decisions I make.
6. After participating in the listening circle, I feel that people have no right to get angry just because they don't like something.
7. After participating in the listening circle, I feel that most of the misfortunes in my life were due to bad luck.
8. After participating in the listening circle, I feel that I see myself as a capable person.

9. After participating in the listening circle, I feel that making waves never gets you anywhere.
10. After participating in the listening circle I feel that people working together can have an effect on their community.
11. After participating in the listening circle, I feel that I am often able to overcome barriers.
12. After participating in the listening circle, I feel that I am generally optimistic about the future.
13. After participating in the listening circle, I feel that when I make plans, I am almost certain to make them work.
14. After participating in the listening circle, I feel that usually, I feel alone.
15. After participating in the listening circle, I feel that experts are in the best position to decide what people should do or learn.
16. After participating in the listening circle, I feel that I am able to do things as well as most other people.
17. After participating in the listening circle, I feel that I generally accomplish what I set out to do.
18. After participating in the listening circle, I feel that people should try to live their lives the way they want to.
19. After participating in the listening circle, I feel that I feel powerless most of the time.
20. After participating in the listening circle, I feel that when I am unsure about something, I usually go along with the rest of the group.
21. After participating in the listening circle I feel that I am a person of worth, at least on an equal basis with others.

22. After participating in the listening circle, I feel that people have the right to make their own decisions, even if they are bad ones.
23. After participating in the listening circle, I feel that I feel I have a number of good qualities.
24. After participating in the listening circle, I feel that very often a problem can be solved by taking action.
25. After participating in the listening circle, I feel that working with others in my community can help to change things for the better.

Social Connectedness Scale (Lee and Lee, 2001)

Answer choices: 1 strongly disagree; 2 disagree; 3 somewhat disagree; 4 somewhat agree; 5 agree; 6 strongly agree)

1. After participating in the listening circle, I feel distant from people.
2. After participating in the listening circle, I feel related to most people.
3. After participating in the listening circle, I feel like an outsider.
4. After participating in the listening circle, I see myself as a loner.
5. After participating in the listening circle, I feel disconnected from the world around me.
6. After participating in the listening circle, I feel that I don't participate with anyone or any group.
7. After participating in the listening circle, I feel close to people.
8. After participating in the listening circle, I feel even around people I know, I don't feel that I really belong.
9. After participating in the listening circle, I feel like I am able to relate to my peers.

10. After participating in the listening circle, I feel like I catch myself losing a sense of connectedness with society.
11. After participating in the listening circle, I feel that I am able to connect with other people.
12. After participating in the listening circle, I feel understood by the people I know.
13. After participating in the listening circle, I see people as friendly and approachable.
14. After participating in the listening circle, I fit in well in new situations.
15. After participating in the listening circle, I have little sense of togetherness with my peers.
16. After participating in the listening circle, my friends feel like family.
17. After participating in the listening circle, I find myself actively involved in people's lives.
18. After participating in the listening circle, even among my friends, there is no sense of brother/sisterhood.
19. After participating in the listening circle, I am in tune with the world.
20. After participating in the listening circle, I feel comfortable in the presence of strangers.

Additional Questions:

Member Checking: The process of member checking includes the primary researcher sharing their findings from their analysis of the listening circles and surveys. The findings will be shared with the participants who requested to participate in this portion of the study during a 30-minute Zoom meeting. Participants who wish to join will discuss the findings, and offer feedback. If you decide to participate in the Zoom meeting, you will receive compensation in the form of a $10 Amazon e-gift card.

1. Would you like to participate in the member-checking process on Zoom?

    a. Yes
    b. No

2. If you selected yes, please share the best email address to reach you at to send the Zoom link.
    a. [short answer response]

Appendix D

Listening Circle Guide

One facilitator (PI)

Co-facilitate (IRB-approved RA and/or faculty advisor)

Time = 75 minutes

Where: Zoom

Listening Circle Researcher Guide

1. Randomize participants to create the circle chart (20 minutes before starting the Zoom meeting)
2. Begin Zoom Meeting
3. Take note of participants as they join the Zoom waiting room and make changes to the circle guide depending on the individuals who show up
4. Let in participants from the Zoom waiting room
5. The researchers introduce themselves and thank everyone for their participation.
6. Project Overview

[script] The research study aims to understand the lived experiences of women with chronic conditions in a post-Roe versus. Wade world. Hearing directly from you will help us understand how policy changes can exacerbate health inequities. This discussion today is not intended to be a discussion about beliefs about abortion itself. In this session, we will be using a listening circle approach to hear from each of you.

7. Review the listening circle background

[script] Listening circles are used to support discussion and understanding of sensitive and personally lived experiences by stimulating intentional conversations, opening consciousness,

and giving voices to those whose stories go untold. The techniques and structure of listening circles foster respect, model good listening skills, and build self-esteem (Mehl-Madrona and Mainguy, 2014; Parker et al., 2021). The structure of the listening circle is designed to invite one individual to speak at a time. Once that individual has finished sharing, the circle will flow in a counterclockwise rotation until each individual has had the chance to speak. In order to be sure that we hear from all participants, and to be mindful of everyone's time, the co-facilitator will share their screen to show the circle for the listening circle portion, and all individuals will have 3 minutes to respond to each question.

Circle Guideline/Values - adapted from Umbreit (2003)

- Speak for yourself and from your own experiences and perspectives. Use “I language” and not generic, “people think. . .” or sweeping generalizations, like “people want. . .” language.
- Be courageous, honest, and open with your own stories. Speak your truth from your heart and be open to hearing others’ truths.
- Listen from the heart, allowing what others say to move you. Bear witness but do not provide advice or argue with others. It is okay to disagree.
- Honor what others say with confidentiality and integrity, sharing only with context and in relevance to your own life and learning, not as gossip.
- Respect the person who is speaking by being fully present, keeping your camera on, avoiding side conversations, and avoiding commenting in the chat while the listening circle is in progress so that each person can convey their full message without interruption.

- When it is not your turn to speak, listen respectfully and reflect upon, consider, and honor the meaning of what others say.
- Sharing is invitational. It is okay to indicate you would like to "pass" on a prompt if you prefer not to respond to it.
- Once you are done speaking, please convey this by saying “I am complete”. This will allow each participant to know when it is their turn to speak, and prevent anyone from talking over one another. Once the person says I am complete the next person may begin talking.
- Allow silence to be a member of the room. Some members may need time while sharing their experiences, as members of the circle we will sit silently with the individual until they feel ready to resume sharing and until the 3-minute
- It is expected that while participating in the listening circle, emotions will come up. This is completely okay and normal. If you feel the need to turn your camera off for a few moments, that is okay, please take the time you need. In these moments, you may feel the desire to pause and acknowledge the emotions presented by your fellow participants; however, in these moments, we will carry on and allow them to take time from the circle if needed instead of pausing the circle process. This will allow us to ensure each participant is still able to answer each question and ensure we do not go over the set time.
- [script] Before we begin, I just want to take a moment and ask if we all silence our cell phones. Additionally, some of you may have participated in a study format where there is commentary and discussion, but listening circles focus on listening and hearing about participants' lived experiences, so as participants we

    will remain silent while others are sharing their experiences, listen attentively, and respond to questions once space is opened up for me after the individual before has acknowledged they are done with the statement “I am complete”.

8. [script] Before we get started, I wanted to check in to see if there were any questions about the guidelines/values I just shared or about the structure of the listening circle experience. The co-facilitator will share her screen so we can see the circle chart full the whole time.
9. Share an inspirational quote to set the ambiance in the circle
    a. I am going to share a quote to set the intentions and atmosphere for us going forward with the listening circle.

- Quote [script] “Sharing empathy is one of the most wonderful aspects of the human experience” - Christine Rose Ellie

10. Begin audio recording

- [script] We will begin the listening circle session and I am going to start recording at this time.

11. Begin questions

Questions

[script] We will start the listening circle with (the participant going first as indicated on the circle chart) and then (the participant going second as indicated on the circle chart) will go. First, we will begin with questions about your day-to-day experiences and then move into questions about the effect of the overturning of Roe versus. Wade.

   a. As you indicated in the initial survey you completed, you have one or more chronic health conditions. What are your day-to-day experiences with your chronic health condition(s)?
   b. [Roe versus Wade is the U.S. Supreme Court case that legalized abortion in the United States in 1973, however, the case was overturned in the summer of 2022, giving the decision back to the states and triggering laws banning and restricting abortion access] As a woman with persistent health conditions, how has your health and well-being been affected since the overturning of Roe versus Wade?
   c. How has the overturning of Roe versus Wade affected your bodily autonomy?
      i. Bodily autonomy is defined as the right to make decisions about your own body, life, and future, without coercion or violence. It includes deciding whether or not to have sex, use contraception, or go to the doctor.
   d. Is there anything else you would like to share about your experiences as a woman with chronic conditions in the post-Roe versus Wade era?

12. End audio recording

13. Closing statement

- [script] Thank you, everyone, for sharing your experiences. I am going to end this circle with this quote, “I define connection as the energy that exists between people when they feel seen, heard, and valued; when they can give and receive without judgment; and when they derive sustenance and strength from the relationship.” -Brené Brown

14. Paste the Qualtrics post-test survey link in the Zoom chat, and direct participants to click the link and complete the survey.

Provide email address as a contact in chat

15. Ask if anyone has questions

16. Thank everyone for participating

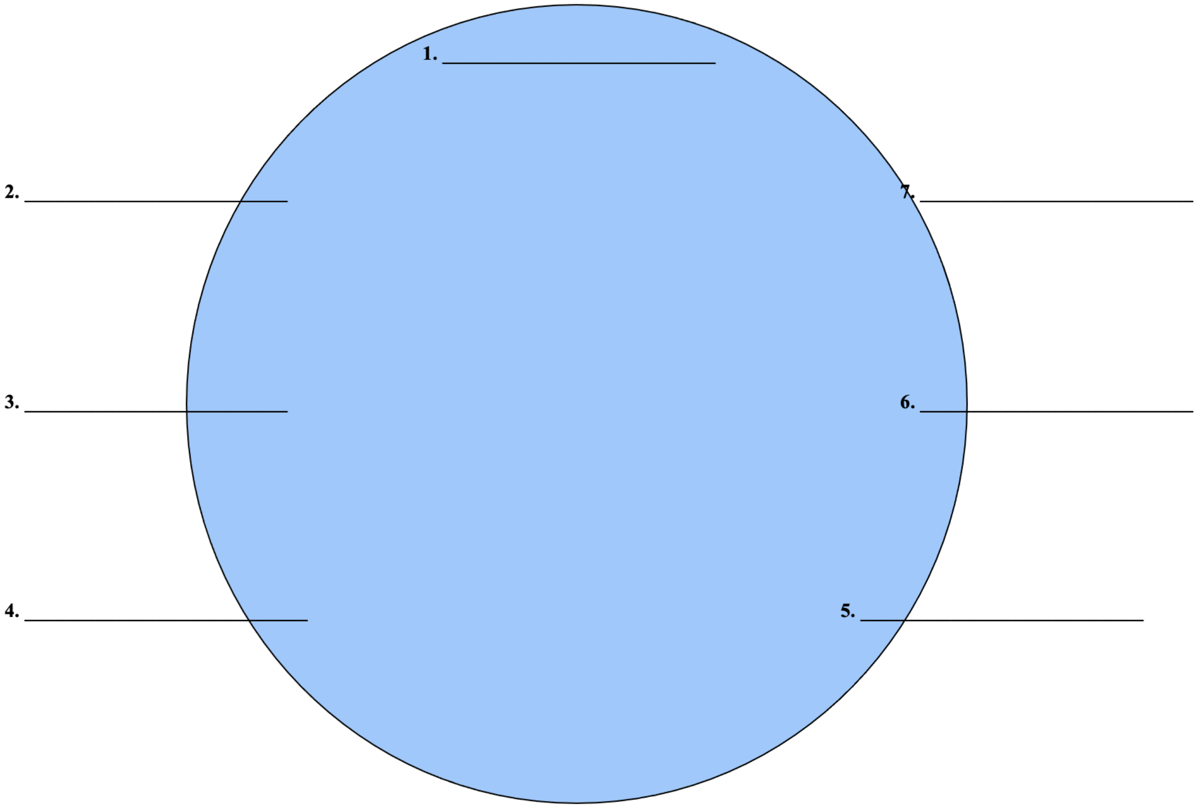
17. End Zoom

18. Delete circle chart

Appendix E

Circle Chart

ONLINE TALKING CIRCLE CHART



Appendix F

Informed Consent - Survey and Listening Circle

Consent to be part of a Research Study

Title of the Project: The Overturning of Roe V. Wade and Unanticipated Effects: Giving Women with Chronic Conditions a Voice Using Listening Circles
Principal Investigator: Payton Davenport, University of North Carolina at Charlotte
Faculty Advisor: Victoria C. Scott, MBA, Ph.D., University of North Carolina at Charlotte

You are invited to participate in a research study. Participation in this research study is voluntary. The information provided is to help you decide whether or not to participate. If you have any questions, please ask.

Please read this form and ask any questions you may have before you decide whether to participate in this study.

Important Information You Need to Know

- Your participation is voluntary.
- The purpose of this study is to understand how the overturning of Roe v. Wade has affected the health and well-being of women with chronic conditions and to see if listening circles are effective at eliciting psychological empowerment and social connectedness.
- You will be asked to fill out additional demographic and study-related questions, participate in an online listening circle using the Zoom platform, and complete two more surveys.
- Your survey answers and responses will be identifiable until the data analysis process is completed. During the data analysis, names will be deleted and thus disassociated with survey responses.
- If you choose to participate it will require a maximum of 90 minutes of your time (the total time spent on Zoom completing the two surveys and listening circle intervention).
- If you choose not to participate, you may withdraw from participating at any point before the listening circle or during the listening circle intervention.
- You can receive a gift card for participating. Gift cards will be issued electronically, 72 hours after participation.
- Risks or discomforts from this research include emotional distress.
- Benefits may include a feeling of empowerment, a feeling of social connectedness, a sense of belonging, and the knowledge of others with similar, shared experiences.

Why are we doing this study?

Roe v. Wade was overturned on June 24, 2022, and has since created numerous unanticipated effects that are impacting the health and well-being of women with chronic conditions. This study aims to increase the visibility of these larger issues by giving these women a voice to share their experiences. Participants will share their lived experiences while participating in listening circles. The second aim of the study is to test the effectiveness of listening circles in promoting psychological empowerment and social connectedness among participants.

Why are you being asked to be in this research study?

You are being asked to be in this study because you identify as a woman, are within reproductive age (18-49 years of age), and have one or more chronic conditions.

What will happen if I take part in this study?

If you choose to participate in this study, you will be asked to answer additional demographic and study-related questions, complete two more surveys, and join a Zoom meeting where you will be asked to participate in a listening circle.

The demographic questions will ask about the following: your age, race, ethnicity, permanent residency, what chronic conditions you have and for how long, how the overturning of Roe v. Wade affected your health and well-being, and how you heard about this study.

After completing these questions, you will then click a link directing you to a SignUpGenius to select a date to participate in the listening circle. No names will be visible. You will only see if there are slots available. When signing up, you will be asked to include your name and email (this will not be visible to other participants). You will then receive an email with the Zoom link for your session, a copy of the consent form, and the link to complete the pre-test survey before participating in the listening circle. The pre-test survey will ask about the following: a) psychological empowerment; and b) social connectedness.

The listening circle will cover your experiences before and after the overturn of Roe v. Wade. Specifically, the questions may ask about how this event has affected your well-being and health. In total, this process will take a maximum of 90 minutes. To participate in this study, you will need an internet connection to join the Zoom meeting. While participating in the listening circle, Zoom will record the audio which will be used for transcription purposes. Only audio will be recorded. No video will be recorded. After the listening circle is finished, you will be asked to fill out a post-test survey. Within 72 hours after the listening circle, you will receive an Amazon e-gift card worth $20.

Additionally, when completing the post-test survey, you will be asked if you would like to review the researcher's findings which will take a total of 30 minutes, and you will earn an additional $10 Amazon e-gift card. If you would like to be included in the member-checking process, then you will be asked to include your name and email address, so the primary researcher can contact you. All contact information and names will be deleted after compensation is received.

What are the benefits of this study?

This study will help inform individuals such as policymakers, healthcare professionals, and researchers on the effects of Roe v. Wade being overturned on women with chronic conditions. In addition, we hope participating in the listening circle will provide a sense of social connectedness and empowerment among participants.

What risks might I experience?

We acknowledge that due to the context of the study, there is a risk that you may experience emotional distress or discomfort while participating in the listening circle. To minimize these possible risks, you will not be asked to share anything you do not want to, and you may withdraw at any point during the study.

How will my information be protected?

We will do everything we can to keep your identity private and your responses confidential. However, given the nature of listening circles, we cannot make guarantees about how others in the listening circle might use your information. We ask that you respect the privacy and confidentiality of the listening circle group members to keep the discussion private and confidential. Only the audio will be recorded during the listening circles for transcription purposes. Video will not be recorded. No names will be attached to the final reporting of themes gathered. If quotes are used in the final report, participants will be given pseudonyms. Audio will be deleted after the member check process is completed. Your survey data will ask for your name so the researcher can determine what data is eligible in the final data analysis portion of the study. After data analysis is complete, all names will be deleted from the survey responses thus your name will be disassociated with your survey responses. Your name will not be used in any final reports and will remain confidential; meaning, a majority will not be able to trace your responses back to you. Again, we cannot guarantee your identity will remain 100% confidential due to the nature of listening circles as addressed above. All survey data, reported findings, and audio recordings, will be protected in a password-protected file and will only be available to the primary researcher, faculty advisor, and other IRB-approved individuals. We will collect your name and email for the electronic gift cards; however; this information will be protected in a password-protected file and will only be available to the primary researcher, faculty advisor, and other IRB-approved individuals. After the study is complete and everyone has received the necessary compensation, the information will be deleted.

How will my data be used?

All surveys will remain as confidential as possible. The only individual with access to the names on the surveys is the primary researcher, faculty advisor, and other IRB-approved individuals. All names will be deleted after the researcher determines what data will be used in the data analysis portion. No IP address will be collected; therefore, nobody will be able to trace your data. We will use your survey data to identify the effectiveness of listening circles in promoting psychological empowerment and social connectedness. Any themes collected from the listening circles will remain anonymous; meaning, no names will be attached to anything said while participating in the circle process. Pseudonyms will be used when the primary research reports the study's findings.

If you decide to provide your email to be included in the member checking process, then your email will be deleted after the review meeting has been completed. When these findings are reported, no names will be associated.

How will my information be used after the study is over?

After this study is complete, identifiers will be removed from the data, and the data could be used for future research studies or distributed to another investigator for future research studies without additional informed consent.

After this study is complete, study data may be shared with other researchers for use in other studies without asking for your consent again or as may be needed as part of publishing our results. The data we share will ***NOT*** include information that could identify you.

Will I receive an incentive for taking part in this study?

You can receive a $20 Amazon e-gift card for participating in this study. You will be eligible for this after the listening circle you attend is completed. You must stay for the full 75 minutes of the listening circle to be eligible for compensation. If you decide to participate in the member-checking Zoom meeting, then you will also be eligible for an additional $10 Amazon e-gift card.

What are my rights if I take part in this study?

It is up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer. If you withdraw in the middle of the study, then your responses during the listening circles will not be transcribed and thus be removed from the study.

Who can answer my questions about this study and my rights as a participant?

For questions about this research, you may contact Payton Davenport, pdavenp1@charlotte.edu, 757.876.3998, Dr. Victoria C. Scott, vscott10@charlotte.edu. If you have questions about your rights as a research participant or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the Office of Research Protections and Integrity at uncc-irb@uncc.edu.

To continue, please select the following on the online survey:
________I have read and understood the information provided above.
________ I agree to participate in this study and understand I have the right to withdraw from the study at any time.
________ I consent to the use of any data for research purposes.
________ I consent to the audio recording of the listening circles.
________ I understand that to receive compensation for participation I must provide identifiable information. This information will be kept separate from the study's data and will be deleted after compensation is distributed.
________ I understand that checking the boxes in the survey and typing my name in the response box are being used as a legal digital signature.

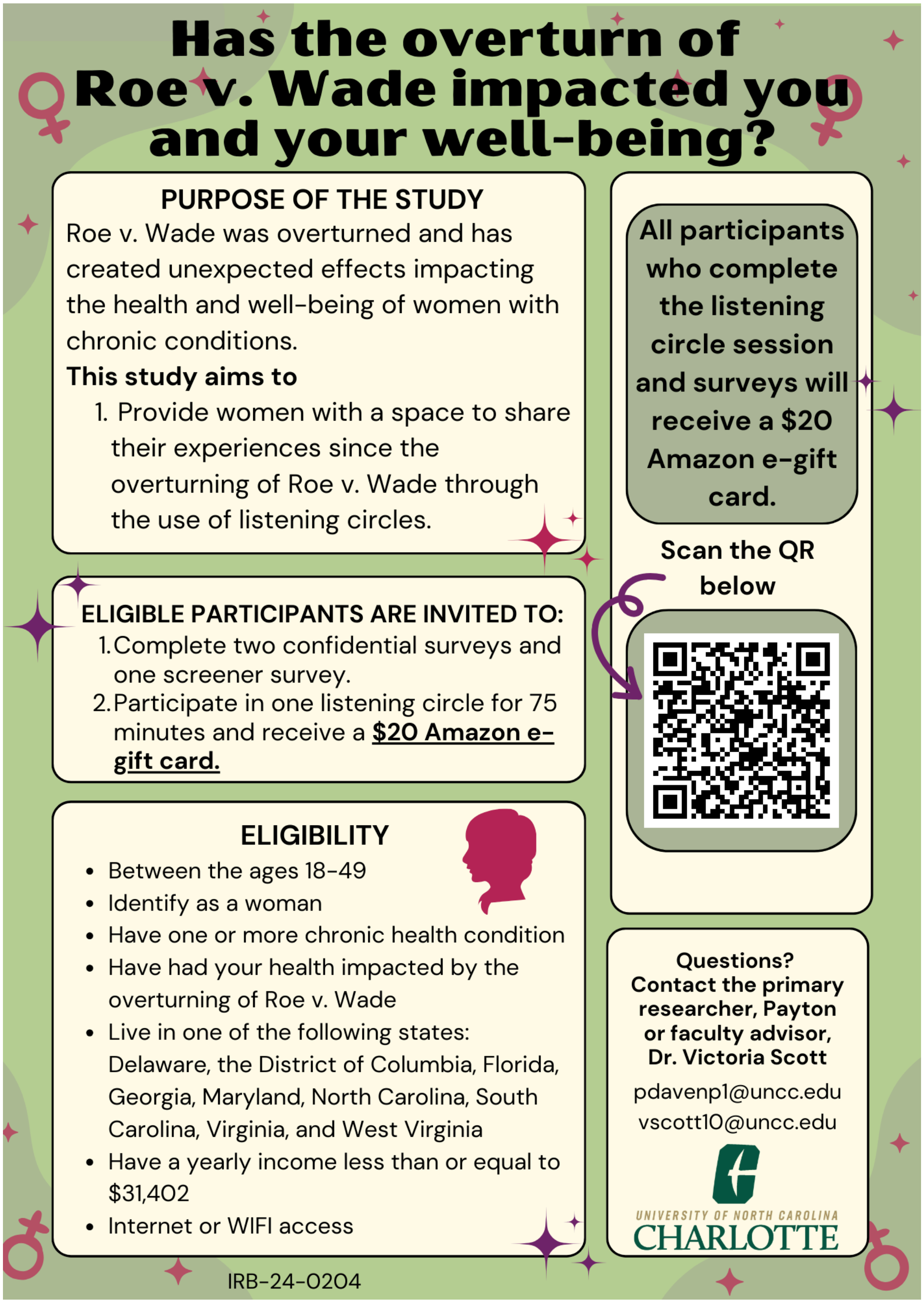
By typing your name in the survey response box and checking the boxes listed, you are agreeing to be in this study. Make sure you understand what the study is about before you complete these actions. You will receive a copy of this document for your records. If you have any questions about the study after you complete the consent process on the survey, you can contact the study team using the information provided above.

I understand what the study is about and my questions so far have been answered. I agree to take part in this study.

To continue, please check the boxes on the survey form and type your name in the response box.

Appendix G

Recruitment Flyer



Has the overturn of Roe v. Wade impacted you and your well-being?

PURPOSE OF THE STUDY

Roe v. Wade was overturned and has created unexpected effects impacting the health and well-being of women with chronic conditions.

This study aims to

1. Provide women with a space to share their experiences since the overturning of Roe v. Wade through the use of listening circles.

ELIGIBLE PARTICIPANTS ARE INVITED TO:

1. Complete two confidential surveys and one screener survey.
2. Participate in one listening circle for 75 minutes and receive a **$20 Amazon e-gift card.**

ELIGIBILITY

- Between the ages 18-49
- Identify as a woman
- Have one or more chronic health condition
- Have had your health impacted by the overturning of Roe v. Wade
- Live in one of the following states: Delaware, the District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia
- Have a yearly income less than or equal to $31,402
- Internet or WIFI access

All participants who complete the listening circle session and surveys will receive a $20 Amazon e-gift card.

Scan the QR below

Questions?
Contact the primary researcher, Payton or faculty advisor, Dr. Victoria Scott

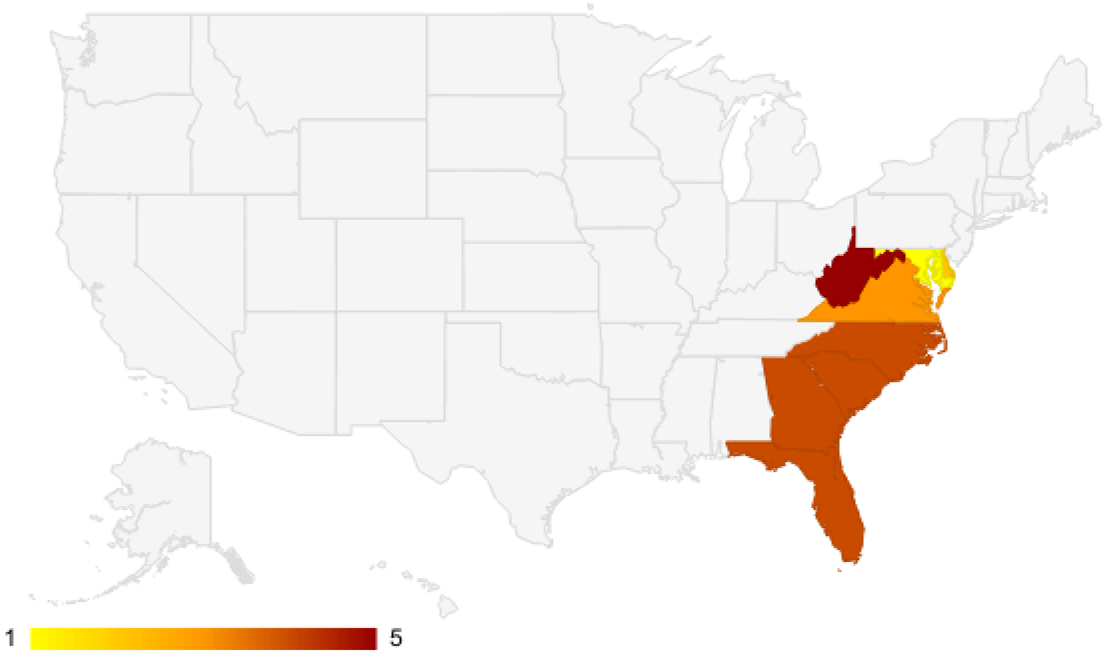
pdavenp1@uncc.edu
vscott10@uncc.edu

UNIVERSITY OF NORTH CAROLINA
CHARLOTTE

IRB-24-0204

Appendix H

Map of Abortion Restriction Level by State



Appendix H. The level of abortion restriction by state (1 - expanded access; 5 - illegal). Adapted from *After Roe Fell: Abortion Laws by State, by Center for Reproductive Rights*, 2024 (https://reproductiverights.org/maps/abortion-laws-by-state/). In the public domain.