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Sex Education or Self Education? LGBT+ Experiences with Exclusionary Curricula

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SEX EDUCATION OR SELF EDUCATION?
LGBT+ EXPERIENCES WITH EXCLUSIONARY CURRICULA

by

KARLI REEVES

A thesis submitted in partial fulfillment of the requirements
for the Honors in the Major Program in Anthropology
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ABSTRACT

Though much research exists on LGBT+ exclusion from school-based sexual and reproductive health (SRH) education, the strategies used by LGBT+ individuals during their search for knowledge regarding the subject are not as widely documented. Using the ethnographic research method of semi-structured interviews, this research explores the experiences of young LGBT+ adults with formal sexual and reproductive health education and examines the self-education methods employed by this population in the context of exclusionary and cisheteronormative curricula. This project also functions to contribute to existing literature in the field of anthropology and other social sciences regarding the subject of SRH education, particularly LGBT+ SRH education. Furthermore, this study supports the need for additional research through the use of applied anthropology concerning interactions between institutions, policy and individual experiences of health.

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CHAPTER 1: INTRODUCTION

School-based education on sex and reproductive health has historically been taught from a perspective that assumes targeted student populations are composed of only cisgender heterosexual individuals (Elia and Eliason 2010). This assumption has led to the creation and implementation of curricula that excludes or alienates individuals who identify as lesbian, gay, bisexual and transgender (LGBT), non-heterosexual, and/or non-cisgender (Elia and Eliason 2010).

The exclusion of LGBT+ representation in school-based sex and reproductive health education has resulted in negative consequences for individuals within the LGBT+ community; including—among others—sexual prejudice and alienation, as well as participation in high-risk sexual behaviors (Blake et al. 2001; Elia and Eliason 2010). Exclusion has also been suggested as one of many factors that contributes to lower school attendance on behalf of LGBT+ students (McGarry 2013). Conversely, inclusive sex and reproductive health education in schools has served to validate LGBT+ individuals and help eliminate anti-LGBT+ biases (McGarry 2013; Chonody, Rutledge and Siebert 2009).

An additional ramification of exclusion from sex and reproductive health education is the creation of alternative strategies for seeking information; in one study, it was documented that gay and bisexual men utilized pornography to supplement their knowledge about sex (Currin et al. 2017). However, pornography has its limitations in that it doesn't necessarily provide information about STIs, while school-based sex education can (but does not always) include this in its curriculum (Blake et al. 2001).

Though much research exists on LGBT+ exclusion from school-based sex education, as well as some of the consequences of said exclusion, the alternative strategies used by LGBT+ individuals during their search for knowledge on sex and reproductive health are not as widely documented. Furthermore, studies that have addressed how individuals within the LGBT+ community supplement their school-based education have usually only addressed gay, lesbian and bisexual identities (Currin et al. 2017). The experiences of transgender individuals are often presented as an afterthought, if included at all. Viewing the topic with an anthropological lens lends a new perspective to research that is traditionally rooted in other disciplines like sociology, education and public health.

In this thesis, I aim to shed light on LGBT+ individuals' experiences with formal sex education and to contribute to existing knowledge of the alternative strategies they use to bridge gaps in knowledge and representation. I argue that the exclusive and cisheteronormative qualities of school-based sexual and reproductive health education, as well as limited SRH education from parents and medical professionals are a form of structural violence enacted upon LGBT+ individuals, and that the strategies used by members of the LGBT+ community to educate themselves are forms of everyday resistance by members of a marginalized group. I conclude by considering the relationship of these strategies to structural changes in sex education.

CHAPTER 2: LITERATURE REVIEW

Anthropological Approaches to LGBT+ SRH Education

Historically, anthropologists have studied LGBT+ issues in a variety of different cultural contexts (Weston 1993). However, anthropological literature on LGBT+ issues in the United States is overall more limited than sociological, public health, and educational research on the matter. LGBT+ SRH education is also traditionally understudied in the field of Anthropology, especially in the context of the United States. Anthropological studies of education, as evidenced have traditionally focused on examining international educational processes within the context of theory, without any necessary emphasis on sexual and reproductive health education.¹ With my research, I hope to build on the existing scholarship regarding LGBT+ representation in sexual and reproductive health education, and to elucidate the strategies utilized by LGBT+ individuals to educate themselves.

History of Sexual and Reproductive Health Education in the United States

There exists an abundance of literature relating to the history of sex and reproductive health (SRH) education within the United States; many of the writings on this subject are situated within educational and legal policy, though non-profit organizations such as Planned Parenthood have made such information more accessible to the public. Before the 1960s, sex and reproductive health education was largely detached from any formal school systems and functioned to address public concerns about perceived “social ills” such as sexually transmitted infections (STIs), sexual expression outside of marriage, prostitution and masturbation (Elia

¹ See: *Anthropology & Education Quarterly* journal’s full [aims and scope](#).

2009). The Sexuality Information and Education Council of the United States (SIECUS) was formed in 1964 by Dr. Mary Calderone, the medical director for the Planned Parenthood Federation of American, in response to the absence of accurate information about matters relating to sex and reproductive health (SIECUS 2018).

Though after the 1960s public support for school-based sexuality education increased in the public sphere, the specifics of said education began to be heavily debated in the 1980s—a reflection of conservative resistance (Kantor et al. 2008). Around this time, two key approaches to school-based sexuality and reproductive health education emerged: comprehensive (also known as evidence-based) and abstinence-only (also known as abstinence-only-until-marriage). The former encompassed biologically and clinically accurate and comprehensive information about sexual health, while the latter insinuated that such a thorough approach would encourage young people to participate in risky sexual behavior (Kantor et al. 2008). This discourse has since dominated the state of school-based sex and reproductive health education in the United States, especially with the introduction and passing of the Adolescent Family Life Act (AFLA) by Congress in 1981. At the time of its implementation, the AFLA was the only federal program relating exclusively to adolescent sexuality and pregnancy and promoted chastity to prevent adolescent sexual activity and pregnancy (White and White 1991).

Other federal abstinence-only-until-marriage programs followed the AFLA; in 1996 the Temporary Assistance for Needy Families Act was signed into law, establishing a new source of funding for abstinence-based education by enacting Title V of the Social Security Act (SIECUS 2018). From 2000 to 2010 the Community-Based Abstinence Education (CBAE) allowed funding for abstinence education through grants awarded directly to state and community-based

organizations, allowing them to make decisions about program funding without receiving approval from their state governments (SIECUS 2018).

Despite a large amount of federal support, abstinence-only education programs are largely ineffective in preventing teen pregnancy (Santelli et al. 2017). Reports released by the Special Investigations Division of the United States House of Representatives (2004) and the Government Accountability Office (2006) have indicated that these programs are not only ineffective but also that they are scientifically inaccurate and even dishonest. The administration of President Barack Obama recognized this inefficiency and decreased funding for CBAE in 2009 before budgeting funding for two new evidence-based sex education initiatives: The Teen Pregnancy Prevention Program and the Personal Responsibility Education Program (Planned Parenthood Action Fund 2019). However, federal funding for abstinence-only sex education programs has since occurred through other means; the Competitive Abstinence Education grant program was revived in 2012 and was replaced by the Sexual Risk Avoidance Education grant program in 2016 (SIECUS 2018).

Though an overwhelming number of parents support evidence-based approaches to sex and reproductive health curriculum, the state of sex education today reflects the dismal legacy of the federal government's encouragement of abstinence-only-until-marriage programs (Planned Parenthood 2019; Santelli et al. 2017). According to the Guttmacher Institute (2018), only 22 states mandate sex and HIV education, while only 13 of those states require that instruction must be scientifically accurate. Information on contraception is only required in 18 states, while 37 states require information about abstinence (Guttmacher 2018). The comprehensiveness of SRH education in the United States differs tremendously with that of countries like the Netherlands,

Finland and Sweden, who mandate evidence-based sexuality education according to WHO guidelines (Ketting and Ivanova 2018).

SRH Education and the LGBT+ Community

While existing literature suggests that the abstinence-only approach to school-based sexual and reproductive health education is ineffective for students of any gender identity or sexual orientation, individuals belonging to the LGBT+ (lesbian, gay, bisexual and transgender) community and other sexual and gender minority students are usually outright excluded from most approaches to sexual education (Elia and Eliason 2010; Hobaica and Kwon 2017). This exclusion of LGBT+ individuals is thought by public health scholars to be a form of systematic erasure and to reproduce sexual prejudice (Elia and Eliason 2010). However, including LGBT+ representation in sex and reproductive health education curriculum does not necessarily have positive effects on sexual and gender minority individuals; some school-based programs do mention LGBT+ identities, but only to demonize them (McGarry 2013). This approach may encompass explicitly condemning LGBT+ people or implicitly referring to non-heterosexual intercourse as “unnatural” (McGarry 2013). Alternatively, only mentioning LGBT+ individuals in the context of HIV or high-risk behaviors can serve to stigmatize their identities further (Elia and Eliason 2010).

Though demonization and stigmatization are very real and harmful side-effects of sex and reproductive health education that inadequately or negatively addresses LGBT+ identities, there also exist additional ramifications for exclusion and alienation. One of these effects is a lack of connectedness between LGBT+ students and their school community, which in turn results in missed classes and consequent diminished learning and identity development (McGarry 2013).

Other considerably dire effects are increased rates of substance abuse, STIs, and poor mental health, especially when compared to heterosexual and cisgender populations (Elia and Eliason 2010). In comparison to LGB individuals, transgender students are especially vulnerable to the negative effects of their erasure in education and their unique experiences of marginalization in school systems; for instance, transgender individuals who reside outside of California and Massachusetts are not legally permitted to use restrooms that align with their gender identity (Simons et al. 2018).

SIECUS encompassed standards for LGBT+ inclusive sex education in their Guidelines for Comprehensive Sexuality Education: Kindergarten through 12th grade (2004), with gender identity and sexual orientation located in the human development section (Elia and Eliason 2010). However, these standards have been criticized for their general approach to inclusive sex education as well as their endorsement of assimilationist politics (Elia and Eliason 2010). On the other hand, GLSEN², an education organization that advocates for LGBT+ issues in American schools, has referred to standards set by the Future of Sex Education initiative in 2012 while also urging educators to go beyond the curriculum in promoting healthy sexual and reproductive development (McGarry 2013). Some of GLSEN's recommendations for school personnel include utilizing gender-neutral language as well as considering how stereotypes are perpetuated in the school environment (McGarry 2013).

² GLSEN was formerly known as the Gay, Lesbian & Straight Education Network, but no longer uses its full name but rather just the acronym in an effort to be more inclusive of all sexual and gender identities (GLSEN 2019).

Theoretical Considerations

Critical Medical Anthropology

Critical medical anthropology is a theoretical approach that is of great use to this research. This approach is primarily used to study health inequalities and proposes that disparities in health are determined largely by structure; ie. institutions like the economy or formal policy (Witeska-Młynarczyk 2015). Critical medical anthropology originated to challenge the field of medical anthropology which in its earlier phases tended to support biomedical assumptions rather than standing apart from them (Singer et al. 1992; Witeska-Młynarczyk 2015). Implied in critical medical anthropology are connections to Karl Marx and Friedrich Engels' social theories that call attention to political and social inequality. The perspective of critical medical anthropology has been subject to many criticisms itself, though the most damaging insinuate that it is unable to consider the lived experiences of the ill in its efforts to concentrate on the macro-level systems that cause suffering (Singer et al. 1992). However, critical medical anthropology is more than capable at being applied at the ground level as well, as exemplified by Paul Farmer's HIV/AIDS research revealing how poverty can contribute to the spread of disease (Farmer 2003).

Critical medical anthropology is applicable to this research because of how it connects macro-level structures to micro-level experiences. In the context of my study, the macro-level structures in question are the institutions of education within the United States. Through ineffective and sometimes outright hostile sex and reproductive health curricula, the educational systems in America shape LGBT+ individuals experiences, and even function to negatively affect their health. This structure is the very factor that might drive LGBT+ students to seek sex

and reproductive health education elsewhere, which is precisely what I have investigated in this project.

Structural Violence

The theoretical approach of structural violence—credited to Johan Galtung, a Norwegian sociologist (1969)—is also significant for my research. This approach holds that social institutions and structures might harm individuals by denying them access to the resources they need to achieve a state of health. Galtung uses the terms “structural violence” and “social injustice” interchangeably, and notes that structural violence is very closely linked to other forms of violence that occur, such as gender and racial violence (1969). Medical anthropologist Paul Farmer has utilized structural violence to approach health disparities, especially in his ethnographic work in Haiti (1992), and his organization’s Partners in Health work in Haiti, Rwanda, and Mexico.³ Other medical anthropologists, including Philippe Bourgois and Nancy Scheper-Hughes, have discussed violence in terms of injustice and suffering (2004).

Structural violence, as a theoretical approach, is useful to my research for many of the same reasons critical medical anthropology is applicable. The experiences of my participants, both negative and positive, were shaped by their interactions with school-based sexual and reproductive health education as an institution. Moreover, I demonstrate in my study that the institutions of the family and the healthcare systems also play a role in structural violence.

³ Partners in Health, 2018.

Everyday Forms of Resistance

Everyday forms of resistance, also known as “weapons of the weak” is a theoretical concept developed by anthropologist James C. Scott to describe different forms of peasant revolt (1985). This approach holds that marginalized groups—who are “weak” in that they possess little social and political power—resist oppression in ways that are often invisible and unorganized (Scott 1985). I will show that in my study, participants can be said to have utilized their own “weapons of the weak” by self-educating in the face of social marginalization and exclusion from SRH education curriculum.

In the subsequent section, I will describe my methodological approach and then follow with two chapters that present my findings and analysis. In the concluding chapter I explain the significance of this project and consider future research direction that could build on these data.

CHAPTER 3: METHODOLOGY

Research Design

This was a qualitative study that aimed to explore the experiences of LGBT+ individuals regarding sexual and reproductive health (SRH) education, as well as the alternative strategies members of this population use to supplement the formal sexual education they receive. The specific research questions (RQs) that I sought to address during this project were:

RQ1: What are the experiences of LGBT+ individuals regarding sexual and reproductive health education?

RQ1a: Do LGBT+ individuals seek information regarding sexual and reproductive health education outside of the public and/or private school systems? For what reason(s)?

RQ1b: Where do they seek this information?

To answer these research questions, I used two different data collection methods: (1) semi-structured interviews and (2) a review of SRH education debates. I explain and justify both methods below.

Semi-structured Interviews

Semi-structured interviews are established within ethnographic research as a method to expose and analyze the beliefs and perspectives of research participants (Bernard 2006). This research method was my most important regarding data collection for this project. From December 2018 to February 2019, I conducted 14 semi-structured interviews; five of these

interviews occurred on the University of Central Florida's Orlando campus, and the remaining nine over the video communication application Skype. I created an interview guide for the purpose of data collection (see Appendix B). The interview guide contained 13 questions and 20 pre-existing probes, though I also listened to informants' answers to respond with additional probes during the interview. Within the interview guide, I pursued four topics: how participants defined SRH education, participants' histories of formal and informal SRH education, participants' self-awareness of their identities throughout their formal SRH education, and the issue of accuracy of information in both formal and informal SRH education. The interviews ranged from 17 to 59 minutes in length. The interviews' dates, times, and locations were determined by each participant. Before the interview took place, participants reviewed an Explanation of Research form (see Appendix C) and gave me verbal consent to take part in this study. Verbal consent—as opposed to written consent—facilitates further confidentiality and it is a common methodological approach in anthropological studies that focus on potentially sensitive topics such as sexuality (DeWalt and DeWalt 2011). All 14 participants granted me consent to audio-record their interviews. I also collected self-identified demographic data about each participant's race/ethnicity, gender identity, and sexual identity. After the interview was completed, I created a de-identified transcript using Microsoft Word. I gave each participant the option to choose a pseudonym; participants who did not choose pseudonyms were assigned one. No participants received compensation for taking part in my study.

Review of SRH Education Debates

Data for this project were also collected from discussions about sexual education within major media venues, such as online news websites, as well as two legislative documents and 10

peer-reviewed journals for the purpose of situating the data collected from participants within the contexts of policy, public sentiment, and existing research. I reviewed documents from sources such as the Center for Disease Control, GLSEN, the Guttmacher Institute and Planned Parenthood (among others).

Recruitment Methods

To recruit for my project, I utilized two locations: (1) recruitment on the University of Central Florida campus, and (2) recruitment on the social media platform Instagram.

For recruitment on the UCF campus, I sought permission from faculty to make short two to three-minute announcements in anthropology classes and distributed my flyer (see Appendix) and Explanation of Research form. Interested participants were able to keep the information and contact me via my Knights email address, which was listed on both forms. I also asked a faculty member from UCF's Department of Anthropology to post a digital copy of my flyer on their Canvas page. I visited three anthropology classes and made a short three-minute announcement in each. Lastly, I requested the permission of LGBT+ Services and the Pride Commons (resource offices for LGBT+ students) to post my recruitment materials.

To recruit via the social media platform Instagram, I created a post on my account that shared the information found on my flyer. I included my Knights email address within the post for any questions or for further correspondence regarding interest in participation. I reposted the project information on Instagram twice during the data collection phase, as old posts disappear from the user's feed.

In both recruitment locations, I utilized snowball sampling by asking research participants to refer additional participants they might know who would be eligible (Bernard 2006).

Sample

I defined eligibility criteria for research participants as English-speaking individuals who were between 18 to 30 years old and identified as LGBT+ (lesbian, gay, bisexual, transgender), non-heterosexual, or non-cisgender. My exclusion of non-English speaking individuals was to ensure that I could comprehend participants without the assistance of a translator, and I limited age to 30 years.

The sample size for my project was 14 individuals aged 19 to 30, who self-identified as follows: 1 gay, 2 lesbian, 7 bisexual, 4 queer, 2 transgender, 3 nonbinary/genderfluid (see Sample Characteristics Table). My inclusion and exclusion criteria allowed me to reach saturation of themes within this sample size (Strauss and Corbin 1998). The final sample size was determined at the point that participants' narratives reached a point of repetition, saturation of themes—when explanations to my questions begin to repeat themselves (Weiss 1995).

Table 1: Sample Characteristics

Research Participant (n=14)	Age	Self-identified Gender	Self-identified Sexual Identity	Self-identified Race/Ethnicity	Type of Formal Sex Education (k-12)
Mercury	24	Transgender, Nonbinary, Genderfluid	Bisexual	White	Abstinence-Only
Gabriel	21	Cisgender Man	Bisexual	Black/White	Abstinence-Plus
Rachel	19	Cisgender Woman	Bisexual	White	Abstinence-Plus
Maria	19	Cisgender Woman	Bisexual	Hispanic/Latinx	Abstinence-Only
Andy	19	Transgender Man	Queer	Hispanic/Latinx	None
Elle	19	Cisgender Woman	Bisexual	Asian	Abstinence-Plus
Emerson	22	Cisgender Woman	Queer	White	Abstinence-Plus
Maeve	21	Cisgender Woman	Lesbian, Queer	White	Abstinence-Plus
Samuel	19	Transgender Man	Bisexual	Hispanic/Latinx	Abstinence-Plus
Erin	30	Nonbinary	Lesbian, Queer	Hispanic/Latinx	Abstinence-Plus
Joshua	21	Cisgender Man	Gay	Mixed Race	Abstinence-Only
Tyler	22	Nonbinary, Transmasculine	Queer	White	Abstinence-Only
Jake	23	Cisgender Man	Bisexual, Gay	White	Abstinence-Only
Laura	22	Cisgender Woman	Queer	Mixed Race	Abstinence-Plus

Reflexivity

Throughout the data collection phase of my project, I only experienced a few challenges. In person recruitment was somewhat challenging, possibly because potential participants might not have wanted to out themselves in front of classmates to take a copy of my flyer. My recruitment on Instagram was much more successful—others shared and reposted my original advertisement for the study, reaching more potential participants. Another challenge I encountered was that I found it difficult to pry and question participants regarding subjects and

periods of their lives that may have been traumatic. Additionally, it makes me uncomfortable to use such information in a research study that benefits me academically.

My positionality as a 20-year-old bisexual woman qualifies me as an insider (in addition to being an outsider researcher) according to the inclusive criteria I selected for participants, and thus, my own experiences provided both a reference and an inspiration for this study (Sherif 2001). However, my positionality also presented challenges as I sought to maintain scholarly distance from the research participants and their narratives (Sherif 2001). Overall, my experiences as a member of the LGBT+ community were more beneficial than harmful. For instance, I was already familiar with most of the terminology used by participants that someone who isn't LGBT+ may not be accustomed to hearing.

CHAPTER 4: SRH EDUCATION AS EXCLUSIONARY/CISHETERONORMATIVE

Exclusion from the Curriculum

Based on my analysis of the interview narratives, I found that LGBT+ individuals were largely absent in the curriculum for the informants in my study who had experienced some school-based sexual and reproductive health education; this was the case for both *abstinence-only* and *abstinence-plus* programs in public and private educational institutions. Abstinence-only education programs teach children and teenagers to abstain from sex and exclude information about contraceptive methods and STI prevention, while abstinence-plus programs heavily emphasize abstinence but do incorporate information regarding contraception and condoms (Advocates for Youth 2019; Santelli et al. 2017). Though having sex before marriage is a relatively common experience in the United States and the average age of sexual debut in the US is 17 (Guttmacher 2017), no participants were ever exposed to truly *comprehensive* SRH programs during their k-12 education. Comprehensive SRH programs attempt to reduce the risk of pregnancy and STIs by incorporating knowledge about condoms, other types of contraception, and by teaching interpersonal and communication skills (Advocates for Youth 2019; Santelli et al. 2017). When I asked Gabriel, a bisexual cisgender man, whether his SRH education at a private religious middle school mentioned LGBT+ identities, he responded “no, it wasn’t even something they seemed to be thinking about. You are going to have sex with a woman—they did say why you shouldn’t and why abstinence would be the best route for you to take...but they didn’t consider the idea that you weren’t going to have heterosexual interaction.”⁴ When asked

⁴ Interview with Gabriel, December 2018.

the same question, Mercury, who identifies as nonbinary and genderfluid, remarked: “not at all...the Midwest [Indiana] isn’t a place for queer people, so it’s just no surprise that we’re erased from the conversation at all regarding education, specifically, sex education.”⁵

Still, there was a notable exception to this exclusion; Emerson, a queer cis woman reflected on a time when her public high school education included a non-heterosexual sexual identity: “so, whenever we talked about HIV, we would talk about how it is more prevalent amongst gay males, that the most prevalent pathway it is transmitted is from gay male to gay male or two men engaging in intercourse. So, the only time that anything wasn’t talked about from a heterosexual perspective was HIV being talked about as transmitted through gay men.”⁶ GLSEN, a US education organization that aims to create safe and inclusive k-12 schools, would conceptualize this experience as falling under “The Stigmatizing Approach” to sex education, which mentions LGBT+ individuals only in the context of risk behaviors, thereby creating a dangerous connotation to LGBT+ identities (GLSEN 2013). Though in the United States, gay and bisexual men *are* the population most affected by HIV, heterosexual individuals still accounted for 24% of HIV diagnoses in 2017 (CDC 2019). SRH education’s conflation of HIV with homosexuality is not only harmful because it stigmatizes LGBT+ individuals; it might also serve to decrease awareness about the disease’s possible transmission in heterosexual interactions.

⁵ Interview with Mercury, December 2018.

⁶ Interview with Emerson, December 2018.

Conceptualization of Identity

Participants in my study indicated that one major impact of not learning about the existence of LGBT+ individuals during education, and especially sex education, were feelings of alienation from the perceived “norm.” This was especially true if they *had* prior knowledge or experiences of negative attitudes towards LGBT+ individuals. Jake, a bisexual cis man, had this experience:

I felt that I wasn’t normal, you know, I couldn’t necessarily relate to the other boys, in terms of like their sexuality or whatever...And even though I had a concept of what gay was and what bisexual was—as internalized homophobia goes—I couldn’t bring myself to identify that with me. Just because, you know, it’s viewed as like such a negative thing. And I was already taught by a lot of people not to embrace my femininity and things like that. And people were telling my mom, when I was nearby, “you don’t want your son to be gay”, like, “you should have him sleep with a girl” or whatever. And I was a child, so that’s problematic and bad and disgusting.⁷

While Jake did have prior knowledge regarding the existence of gay and bisexual people, he did not learn about them in an educational setting. Though education is not immune to the biases of the instructor and/or the curriculum, it does provide an opportunity for a child or adolescent to be exposed to an idea their parent(s) or caretaker(s) may not address in the home environment, and hypothetically allows for a more factual source of information (given that the information is, indeed, credible). It also stands to reason that if SRH education included positive LGBT+ representation, it might function to counteract any potential negative biases regarding LGBT+ individuals in the home environment; at the very least, any conflicting information may cause a student to regard what they hear with scrutiny.

⁷ Interview with Jake, February 2019.

An alternative ramification of LGBT+ exclusion from SRH education was the inability of some informants to conceptualize their own identities, which contributed to confusion and even identifying with incorrect labels later in life. Joshua, who identifies as a gay cis man, remarked upon his experience:

And like I even had one girlfriend in middle school...we were like friends and then like we dated for ten months and we never had sex, but we were very physically intimate; we made out a lot. But I could always tell that she like felt something, and I ended up breaking up with her because I like literally felt zero physical attraction towards her. And so, for a long time I thought it was asexual because I found out what that was—thanks to the Internet—and I was like, “oh, that must be me because I don't feel anything for anybody”.⁸

Elle, a cis woman that identified as asexual for most of her time in high school and only recently began identifying as bisexual, noted: “I think that if I had been introduced to the idea of bisexuality or pansexuality when I was younger, it probably wouldn't have taken me quite as long to figure out what was going on as it did in real life.”⁹ Joshua's experience in particular reflects the uncertainty that follows when trying to perform within the confines of a heteronormative identity, as well as the corresponding struggle to define himself without the necessary label to do so.

Sex for Reproduction, Not for Pleasure

The formal SRH education experienced by my informants did not only exclude LGBT+ individuals from the curriculum—it also perpetuated cisheteronormativity by inextricably linking the act of sex with reproduction. Laura, a queer cis woman, reflected upon her experiences with sexual and reproductive health education in eighth grade:

⁸ Interview with Joshua, January 2019.

⁹ Interview with Elle, December 2018.

So, they talked about sex, like you know “this is what a penis is, this is the vagina, here’s the diagram of each and then we’ll talk to you about the ins and outs. And then also when the eggs get inseminated, you know, that causes pregnancy” and how that would happen. Again, it was all a very scientific aimed kind of thing. It didn’t really talk about the emotional aspects or the intimacy aspects of sex. And again, it was all very heterosexual.¹⁰

Emerson’s recollection of her experience at age 10 was almost identical to Laura’s: “we learned about the parts of the reproductive organs of the male and female sexes. We didn’t talk about gender identity or anything, just typical male and female genitalia, as well as the actual biological processes of reproduction...”¹¹ Andy, a transgender man, did not have formal SRH education, so he only learned about sex in a school context during a biology class; the curriculum was similarly technical: “it didn’t really cover anything about the practice, only the end result [pregnancy]...they kind of failed to go into detail.”¹² It is particularly striking that informants’ experiences with formal SRH programs mirrored that of a biology class, especially given that focusing on the technical aspects of sexual reproduction might make sense in the context of a biology course. Technicality is less logical in an education program designed to educate individuals about sexual behavior and practice, which can obviously occur outside of the confines of heterosexuality or reproduction. Additionally, the collective experiences of Laura and Emerson bring into question the specific goal of SRH education; if sex education only addresses the biological aspects of reproduction to ensure that students are aware of how to avoid pregnancy, it is failing to consider that heterosexual and cisgender individuals are not the only ones who can become pregnant.

¹⁰ Interview with Laura, February 2019.

¹¹ Interview with Emerson, December 2018.

¹² Interview with Andy, December 2018.

On the other hand, the narratives in this study show that for many participants, pleasure was disassociated from sexual activity in the context of formal SRH education. In their interview, Mercury related that the first time they learned about sex being pleasurable was in college, during a women's studies course: "...as a grad student, I'm supposed to be my own educator and producer but at the same time, not knowing my own body is actually really terrifying...honestly, I never even had my first orgasm until a couple of years ago."¹³ In one participant's experience, the female body was especially alienated from pleasure. Rachel, a bisexual cis woman, indicated in her interview that during her school sex and reproductive health education, a diagram of the vagina lacked a description for the clitoris, only possessing a label for the part; every other section included both a label *and* description.¹⁴ This detachment of pleasure from sex—known in the scholarship as “the pleasure deficit”—in the field of reproductive health is particularly guilty of conceptualizing sexual intercourse as an act devoid of both enjoyment *and* pain (Higgins and Hirsch 2007). The problem of “the pleasure deficit,” which is evident in my research participants' narratives, highlights how this deficient approach continues to be used by school-based SRH education.

Condoms Are the Only Barrier Method

The disassociation of sex and pleasure was further perpetuated by the exclusion of non-condom contraceptive and barrier methods. Two participants noted that their formal SRH education failed to mention the existence of dental dams, a barrier method used between the mouth and vagina or anus during oral sex (CDC 2016). Samuel, a transgender man, explained:

¹³ Interview with Mercury, December 2018.

¹⁴ Interview with Rachel, December 2018.

They don't give people the resources they need to have safe sex. So, they'd never talk about contraception for AFAB people—people assigned female at birth—so like, the pill, the IUD, stuff like that...So, for example, it is like a huge misconception that people who are lesbians can't get any kind of STI because there's no actual penetration but you can have things transmitted through oral sex, you know? Through toys and everything like that. A lot of people—I found out—don't know what dental dams are...It's a huge thing that they are not mentioned at all. Like, if you want to know what dental dams are, find out on your own. I didn't find out until college, and that's because I saw them and then I read the back and there are the instructions and I was like "oh, interesting".¹⁵

Of course, such a method can be utilized during sex for anyone of any identity, however,

Planned Parenthood advises (2019) the use of dental dams for women who have sex with other women.

Additionally, including condoms as a contraceptive method only functioned to perpetuate sex as a heteronormative act of procreation further. This is because condoms were not indicated to have any value past preventing pregnancy or the transmission of STIs between heterosexual partners. Gabriel remarked on his education about condoms:

I think one of the things that they did get correct was warning that if you did have sex, you should always be wearing a condom, at least for the boys. And I think that does cover—not in the sense that they specifically covered it—but in the sense that if you say that condoms are generally a good idea for men having [heterosexual] sex, then men who are having homosexual sex would possibly think to wear condoms. I do think that there is a big hole in the idea, since we're eighth graders, of not specifically saying it.¹⁶

Jake did not have any education regarding STIs and indicated that more than one of his male partners wanted to have sex without a condom.¹⁷ After doing independent research on safe sex, he felt that the risk of STIs—particularly HIV—for queer people is something that needs to be taught.¹⁸

¹⁵ Interview with Samuel, January 2019.

¹⁶ Interview with Gabriel, December 2018.

¹⁷ Interview with Jake, February 2019.

¹⁸ Interview with Jake, February 2019.

Cisheteronormativity of Consent Framework

Participants in my study did not only indicate that LGBT+ individuals were excluded from information regarding sexuality and reproductive health. The few informants who indicated that they had experienced school-based education regarding consent and sexual assault informed me that it was similarly cisheteronormative. Laura, a queer cis woman who attended public school, learned about consent in third grade: "...they gave us this little booklet and it was about this babysitter who was maybe fifteen, and she wants to practice what she's watching on TV on this eight-year-old. In the booklet you learn how to say 'no' and 'this makes me uncomfortable' and that kind of thing."¹⁹ Elle's education defined sexual assault in a different way:

Sexual assault and rape were always defined as happening to a girl because of men. Like, a man's doing it when you're in college, but if it happens when you're a kid, it's always going to be an adult figure, like a grandpa or uncle or family friend. It's never going to be somebody who's your age...It's always going to be a figure or authority. Somebody who has power. Or like a stranger at a party or something.²⁰

Unfortunately, Elle was sexually assaulted by another girl as a pre-teen and was unable to conceptualize what was happening as assault; she informed me: "I would have reported it if I had understood what it was at the time and that's where a lot of my anger comes from. Like, at my sexual education. It's because they didn't teach me enough to understand what was happening to me, and if I had understood I would have reported it and it could have been dealt with before I had any of the shame attached to it."²¹ It appears that because Elle's education indicated that sexual assault was perpetuated solely by men, she could not interpret her experience with a girl in those terms. While Laura's education *did* portray a female perpetrator of assault, it still

¹⁹ Interview with Laura, February 2019.

²⁰ Interview with Elle, December 2018.

²¹ Interview with Elle, December 2018.

presented a similar power imbalance to the one Elle referenced; both experiences reflect a failure on the part of the school to stipulate that anyone—even other children of the same age and gender—can execute sexual assault or abuse.

Cisheteronormativity as Structural Violence

According to GLSEN and the Centers for Disease Control and Prevention, LGBT+ youth in the United States are more vulnerable to certain health risks than their heterosexual counterparts (2015; CDC 2017). Sexual minority women are more likely to experience teen pregnancy than heterosexual women, while gay and bisexual men experience higher rates of STIs than their straight peers (Charlton et al. 2018; CDC 2013; GLSEN 2015). LGBT+ youth are also less likely than heterosexual youth to use condoms or other contraceptive methods, are more likely to participate in other risky sexual behaviors, such as having sex while under the influence of alcohol or other substances, and are additionally more likely to be the victims of dating violence and nonconsensual sexual intercourse (GLSEN 2015; CDC 2017).

The disparities between LGBT+ and heterosexual/cisgender youth are consequential. While of course, these disparities could certainly originate from many different factors, it would be myopic to not contextualize them within the institution of school-based sexual and reproductive health education. This is especially true given that comprehensive—but not necessarily LGBT+ inclusive²²—SRH programs in countries like Netherlands, Germany and

²² Dutch law requires that schools in the Netherlands include information about sexual diversity in their curriculum, however, to what extent such information is included is unclear, and varies by municipality (COC Nederland et al. 2014).

France have contributed to lower rates of teen pregnancy and STI and HIV transmission in the overall population (Planned Parenthood 2014; Schalet 2011).

US school-based SRH education is detrimental to LGBT+ individuals through its exclusivity and perpetuation of cisheteronormativity, and thus, analyzing the institution's limitations in the context of structural violence is productive, and represents a critical medical anthropological approach of how systems affect individual health. Structural violence occurs when a social structure or institution—in this case, United States school-based sexual and reproductive health education—causes harm to people by preventing them from accessing their basic needs—in this context, knowledge regarding sexual and reproductive health—and by perpetuating existing social inequalities—the marginalization of LGBT+ individuals (Farmer 1996; Galtung 1969). Exclusion and heteronormativity are structurally violent in that they prevent LGBT+ individuals from being exposed to information regarding consent frameworks and safe sex methods relative to their identities. This, of course, can have an impact on their physical and emotional health, and is likely linked to the differential rates of STIs, pregnancy, and sexual assault as experienced by the LGBT+ population.

Elle described the emotional toll her sexual assault had in her interview: “It sucked. There’s really no other way to put it. It was something that changed my brain chemistry and I’m still on an SSRI²³ today, and I will have to be for the foreseeable future...I had my breakdown last year and I ended up in the hospital for four days. I’m a year behind in my studies because I dropped out last fall and had to take spring off because it was a medical withdrawal.”²⁴ As she

²³ SSRIs are selective serotonin reuptake inhibitors, which are most often used as antidepressants.

²⁴ Interview with Elle, December 2019.

indicated previously, she was unable to understand what happened to her as being sexual assault, specifically *because* her education at school portrayed the experience as being a strictly heterosexual one. Because of this, she didn't know to report the assault until years later, when it had already significantly impacted her mental health.

Exclusion and heteronormativity in SRH education also negatively affected Jake's mental and physical health: "when I first started having sex, the person didn't try to prepare me at all, and he was very dominant over me and made me feel like I had to just deal with the pain...I feel like when I was learning about straight sex, if they had just been like 'this is how gay people have sex', then it would have been easier and safer for me."²⁵ While not an identical experience, Mercury informed me that more than one of their transgender friends have become pregnant because they didn't know that it was a possibility while on hormone replacement therapy²⁶. Because heterosexual sex is not identical to non-heterosexual or non-cisgender sex, excluding the latter two in SRH education is actively denying LGBT+ individuals crucial information that they require to participate in safe and healthy sex and relationships, and thus, a manifestation of structural violence.

While this chapter focused on the experiences of my study participants with exclusionary and cisheteronormative sex education system, in the next chapter I examine the strategies they use to fill in the gaps left by their formal schooling.

²⁵ Interview with Jake, February 2019.

²⁶ Interview with Mercury, December 2018.

CHAPTER 5: EDUCATION STRATEGIES

This chapter builds upon the exclusivity and cisheteronormativity experienced by the participants in my study in the previous chapter to present corresponding information about the different strategies that my informants used to supplement their k-12 sexual and reproductive health education. Specifically, this section addresses sources of such knowledge such as the participants' parents, doctors and other medical professionals, and most commonly, websites found on the Internet.

Where Were the Parents?

The narratives of some participants in this study brought attention to their parents' role—or lack thereof—in educating them about sex and reproductive health. Joshua's parents provided him with sexual education, however, it was extremely heteronormative in that it anticipated he would have sex with a woman.²⁷ Gabriel described his parents as being open to talking about the subject, but not feeling the same way:

And of course, there is the sexual education that your parents try to give you—and my parents tried to be very open about that—but in doing so they said “if you have any questions, if you want to talk about it, come talk to us,” and the burden of that kind of was placed on me. In general, I'm not going to do that because I didn't feel comfortable talking to my parents about that.²⁸

Tyler, who identifies as queer and transmasculine, remembered his father leaving a book about puberty on his bookshelf when he was in fourth or fifth grade, but not any additional discussion offered by his parents.²⁹

²⁷ Interview with Joshua, January 2019.

²⁸ Interview with Gabriel, December 2018.

²⁹ Interview with Tyler, February 2019.

On the other hand, Rachel—who identifies as a cisgender bisexual woman—received a large amount of information regarding sex and reproductive health from a parent, just not her own: “But mainly what I learned was from my girlfriend at the time’s mom. She was very open—she was like Regina George’s³⁰ mom—she was like ‘anything you guys need...’ you know, that type of person?”³¹ However, her experience was not by any means the norm. In fact, Rachel’s own parents completely rejected people who were attracted to the same gender, stating that they had “evolved wrong” and that “natural selection will take care of them eventually.”³² Other parents also exhibited varying degrees of homophobia and/or transphobia, which coupled with the general discomfort of discussing sex with a parent, discouraged participants from asking questions on the subject. Maeve, a cisgender lesbian, recalled: “the environment I grew up in, it was definitely something you shouldn’t talk about, especially toward my dad’s side of the conversation.”³³ When Erin came out to their parents as a lesbian, they took them to a therapist and an evangelical sexologist.³⁴ Quite a few of the participants in this research were not “out” to their parents, despite their college age, for fear of something similar happening to them. Overall, the roles of participants’ parents in their sex education varied from completely hands-off to tentatively involved—though not a single informant mentioned receiving an LGBT+ inclusive education from either parent. This is not extremely surprising—research indicates that American

³⁰ Regina George is the antagonist of the teen comedy film *Mean Girls* (2004). When Regina’s mother, Mrs. George (played by actress Amy Poehler), walks in on her kissing a boy, she offers her daughter “some snacks, [or] a condom” (Dróž 2017). This scene has a humorous effect due to Mrs. George’s nonchalant attitude about her daughter’s sex life, which contrasts with the audience’s expectation for her to become angry.

³¹ Interview with Rachel, December 2018.

³² Interview with Rachel, December 2018.

³³ Interview with Maeve, January 2019.

³⁴ Interview with Erin, January 2019.

parents are unlikely to negotiate teenage sexuality within the home in a *heterosexual* context (Schalet 2011).

Education from Medical Professionals

Like their parents, the informants' doctors did not contribute much to their sex education. For Gabriel and Joshua, the conversation has never come up during appointments—though they are not particularly opposed to speaking about it.³⁵ Gabriel commented on the matter: “I think that I would be comfortable talking about it [his bisexuality] with a doctor, but it just hasn’t really come up as information I would need to share with them, so I haven’t tried.”³⁶ Jake has likewise never discussed his sexuality with a doctor, and would not feel comfortable doing so; he explained why: “you know, even though I think it’s obvious that I’m gay, I wouldn’t even think to tell my doctor...’cause like, actually saying that I’m gay, I feel uncomfortable.”³⁷ It is my understanding that Jake’s viewpoint—and the feelings of others who expressed similar sentiment—might originate from past experiences of homophobia and/or fear of discrimination.

Notably, three participants have discussed their sexual identities with a medical professional, however, none of them were seeking information, and only one learned something new. Andy, for example, remembered discovering his risk of catching an STI during a routine test: “I got tested for a couple things and they kind of went over my results and the guy [an employee of Student Health Services] who went over my test was bisexual and he taught me about things that could apply to me, which I found helpful. He didn’t come at me from a

³⁵ Interview with Gabriel, December 2018; Interview with Joshua, January 2019.

³⁶ Interview with Gabriel, December 2018.

³⁷ Interview with Jake, February 2019.

heterosexual stand point.”³⁸ The overall lack of involvement of doctors in providing sex education to their patients may be related to the fact that in the state of Florida,³⁹ there are no specific legal provisions that expressly authorize minors—individuals under the age of 18—to consent to general medical care, meaning that a parent or guardian may have to approve the individual’s appointment—and may also accompany them (English et al. 2010). Additionally, doctors may divulge information to parent or guardian of a minor patient so long as it is not regarding the consultation, examination, and treatment of a sexually transmitted disease (English et al. 2010). If an individual is not out to their parents, they might not feel comfortable asking questions pertaining to their sexuality in front of them during an appointment.

SRH Self-Education

Given that none of the research participants in this study received adequate SRH education from the social and educational institutions in their lives (families, schools, healthcare providers), they inevitably ventured onto the World Wide Web—colloquially referred to as the “Internet”—to add to (or correct) their knowledge regarding sex and reproductive health. Participants indicated that they used a variety of different sources to educate themselves that ranged from evidence-based—such as advocacy sites—to a variety of popular but not science-based sites—including (but not limited to) personal blogs, forums, pornography, and fanfiction websites.

Completely “evidence-based” sources of information—which incorporate the best available findings from systematically conducted and peer-reviewed research—for sex and

³⁸ Interview with Andy, December 2018.

³⁹ Twelve out of 14 of my participants attended grades k-12 in the state of Florida.

reproductive health information were not overwhelmingly used by my study participants for self-education. Only three informants indicated that they used sources that might qualify as “evidence-based” and specified that they were used in combination with somewhat or not “evidence-based” sources. For instance, Mercury indicated in their interview that they remembered “advocacy groups, reproductive justice advocacy groups, as well as queer and trans advocacy groups that have some sort of websites,” but that they did not “know any specifically.”⁴⁰ Likewise, Laura could not name any particular website, but said that she had “always been taught the importance of finding good sources” and “would go to either organization websites or government websites—just things that looked official.”⁴¹ Maria—a bisexual cis woman—also sought to find reputable sources for her information; however, she informed me that she “used the MayoClinic, and other medical websites” because she “thought they were factual and accurate” and because she “trusted a medical institution more than a random blog or something.”⁴² Samuel, a transgender Colombian man who was shocked by the emphasis that the American educational system placed on abstinence, also prioritized accuracy; however, he did not name any evidence-based sources in his interview, and instead verified the information he found on YouTube by cross-referencing it.⁴³ Because neither Mercury nor Laura could remember the specific websites they used to find knowledge regarding SRH education, it is impossible to evaluate how credible their sources were. However, what *is* indicated by their

⁴⁰ Interview with Mercury, December 2018.

⁴¹ Interview with Laura, February 2019.

⁴² Interview with Maria, December 2018.

⁴³ Interview with Samuel, January 2019.

experiences—alongside those of Maria and Samuel—is that the quality (credibility) of the information was most important to them.

This is not to say that the participants who used other somewhat or not “evidence-based” sources did not care about the trustworthiness of the information they found. For instance, though Gabriel “had been told not to trust Wikipedia” he noted that he “would just go straight to Wikipedia to get scientific information.”⁴⁴ Gabriel’s phrasing is particularly interesting because it indicates both that he valued a scientific approach to learning and that he interpreted Wikipedia as a reliable source. Wikipedia’s legitimacy as a source of information is disputed due to website’s editability by virtually anyone; academic studies on Wikipedia have found that its health-specific articles are accurate overall, while others conclude that it is not suitable as a learning resource for medical students (Bould et al. 2014; Azer 2015). Ultimately, a child or adolescent using Wikipedia to learn about sex and reproductive health might not require the same breadth of information as a medical student, which might have made it a suitable resource for Gabriel. However, given that his SRH education occurred more than five years ago, determining the accuracy of the different pages he visited is not feasible.

Even the participants who previously stated they have utilized “evidence-based” sources sought additional information elsewhere. For instance, Mercury recalled their experience seeking information from strangers: “I also went on website forums, chatrooms, which was kind of—after thinking about it—appalling. Relying on someone I don’t know, and I’ve never seen before in my life to tell me what sex education is.”⁴⁵ In contrast to information provided by advocacy

⁴⁴ Interview with Gabriel, December 2018.

⁴⁵ Interview with Mercury, December 2018.

organization websites like that of the LGBT+ Center Orlando or Planned Parenthood, anonymous individuals in chatrooms do not have any accountability required of them; thus, any advice they give cannot be verified without additional research. These risks exist in addition to the dangers that may be associated with contacting strangers who have unknown motives.

Similarly anecdotal as forums and other social media platforms, blogging websites like Tumblr also served as a source of information for some participants, including Laura.⁴⁶ Maeve also used Tumblr, but in a different manner than Laura—to read fanfiction⁴⁷ written by users; she recalled:

It was sites like Tumblr, sites like FanFiction.net and AO3⁴⁸ that really introduced me to sex with people of the same gender and everything. Through those stories and through those conversations, they talked about reproductive health, they talk about sex safety and everything. And through that I was able to search the web about condoms and anal sex and dental dams, which I did not know existed until I read about them.⁴⁹

Rachel also used fanfiction for the purpose of self-education. Like with Maeve, her experience indicated a pattern of initial exposure to a term or act in fanfiction, followed by a secondary Google search to find more information: “around ninth grade I was reading a lot of fanfic—I was like ‘I wonder how accurate this is’ and did some Googling.”⁵⁰ Elle, on the other hand, credits only some of her knowledge regarding sexual practices to fanfiction; she also gathered information on the subject from Neil Gaiman’s novel *American Gods*⁵¹, and television shows

⁴⁶ Interview with Laura, February 2019.

⁴⁷ Fanfiction, informally known as “fanfic,” is “fiction written by fans of a TV series, movie, etc., using existing characters and situations to develop new plots” (Dictionary.com, LLC. 2019).

⁴⁸ AO3 is an abbreviation for Archive of Our Own, a “a noncommercial and nonprofit central hosting site for transformative fanworks such as fanfiction, fanart, fan videos and podfic” (Organization for Transformative Works 2019).

⁴⁹ Interview with Laura, February 2019.

⁵⁰ Interview with Rachel, December 2018; Interview with Maeve, January 2019.

⁵¹ *American Gods* (2001) is an adult fantasy novel by English author Neil Gaiman; Chapter 7 notably contains an explicit sex scene between a human man named Salim and a djinn named Je (Gaiman 2001).

like *Game of Thrones*⁵².⁵³ The reality of the matter is, these types of media are fictional. This is not to say that each and every act or bit of information is inaccurate, but merely that the purpose of fanfiction or television is to *entertain*, not to educate. Thus, the so-called “secondary Google search” might function to provide the necessary factual elements to the equation as participants in this study sought to fend for themselves in the area of sex education.

Certainly, media intended for entertainment is not reliable enough to be used as a source, something that was illustrated in Erin’s interview. Erin—a nonbinary lesbian—accounted their experience after they looked to the show *The L Word*⁵⁴ for guidance:

It wasn't until two or three years ago that I was listening to—now podcasts are a real thing—but I was listening to Cameron Esposito, her show *Queery* and she was like, “*The L Word* is a soap opera.” And it clicked in my head, I was like, “oh it is legit, a soap opera of experience; it is not a reality.” But it was all we had. And so, like I was like “damn, it was a soap opera and I thought that it was normal,” you know?⁵⁵

Erin did not indicate that they suffered any particularly negative repercussions from using entertainment for self-education, but that such “sources were too narrow” in that they established rigid norms and perpetuated the “need to fill a stereotype.”⁵⁶ A similar sentiment is echoed in Jake’s experience with pornography:

I guess in learning about gay sex, obviously porn is huge, and no one really teaches you how to have anal. I started watching gay porn when I was like 13...and I didn’t really understand how gay people had sex. I thought it was just kind of similar [to heterosexual sex]. Like, I understood that it was anal, but I didn’t really think about the process of being able to have sex, and how you really have to work up to it. And like, it shouldn’t

⁵² *Game of Thrones* (2011-2019) is an American fantasy television series based on the *A Song of Ice and Fire* book series by author George R.R. Martin. It is broadcasted on HBO and is somewhat infamous for gratuitous nudity and sex scenes (Home Box Office, Inc. 2019).

⁵³ Interview with Elle, December 2018.

⁵⁴ *The L Word* (2004-2009) was an American-Canadian drama series broadcasted on Showtime that focused on the lives of a group of lesbian and bisexual women who lived in Los Angeles, California (Showtime Networks Inc. 2019).

⁵⁵ Interview with Erin, January 2019.

⁵⁶ Interview with Erin, January 2019.

always be painful, and that the ass doesn't work like a vagina obviously. But you know, watching porn, it's very glorified, it's made to seem easy and kind of just like whatever. And then also porn can be really toxic, and just the kind of roles that are perpetuated in a lot of different scenes... Obviously, I'm the bottom, I'm the receiver, like pretty much every time that I've had sex. And so, I kind of have pressure on me to perform to a certain character or certain roles and tasks as a person. I feel like it's possible that those are definitely learned behaviors that I have gotten through my queer sex education and watching porn.⁵⁷

Pornography, like fanfiction and television programs, is another medium of entertainment. As illustrated by Jake's account, it is ill-equipped to educate individuals about how to have sex, and appears more apt to perpetuate harmful stereotypes, especially for LGBT+ individuals who do not have as much overall television representation as cisgender and heterosexual individuals (GLAAD 2018). The prevalence and accessibility of pornography makes this all the more worrisome, particularly with the consideration that heterosexual men are targeted as a major audience of lesbian pornography, while gay male pornography is a popular choice for heterosexual and bisexual female users (Puhl 2010; Neville 2015). Certainly, the producers of pornography are privy to the demographics of their audience, and may opt to include scenes that the consumer finds exciting—scenes that might not have much instructive value to LGBT+ users. Thus, pornography perpetuating stereotypes, or even dangerous sexual behavior such as not wearing a condom disqualifies it from being an effective and factual method of self-education (Schrimshaw 2016).

Self-Education as a Form of Everyday Resistance

LGBT+ individuals are marginalized in countless ways; they face personal experiences of discrimination—verbal and sexual harassment, microaggression, and violence—alongside forms

⁵⁷ Interview with Jake, February 2019.

of institutional oppression—such as wage inequality, when applying for jobs or housing, and in the medical and criminal justice systems (Harvard 2017). LGBT+ individuals experience further oppression in school, when they are excluded from SRH education curriculum and denied knowledge vital to their sexual and reproductive health and relationships.

In response to their exclusion, many LGBT+ individuals conduct an independent search for information to educate themselves and fill the gaps in knowledge their formal education has left them with. This self-education can be conceptualized as a form of “everyday resistance”, a concept that encompasses the subtle but powerful ways marginalized groups respond to their domination; traditionally, this concept was applied to reflect the cultural resistance of peasant societies known as “weapons of the weak” (Scott 2008). Scott’s use of the word “weak” in reference to the populations he studied did not denote frailty; instead, it was a reference to their vulnerability and lack of social and political influence (2008). In the context of Scott’s theoretical lens, my research participants could likewise be considered “weak” due to being children and adolescents at the time of their SRH education—not to mention their relative social vulnerability as members of the LGBT+ community. Scott’s forms of “everyday resistance” are also a useful way to approach the informants’ experiences with SRH education because their “rebellion” against the institution was not overt. For example, Erin’s approach to their formal SRH education was to pick and choose what they paid attention to, while ignoring the rest: “I knew I was gay and so all of the information about menstruation, I used that information, but

there was nothing more so I just shut off for the rest of it.”⁵⁸ Erin then used other pathways of information to seek information that *was* relevant to them.⁵⁹

Samuel also resisted, though in a different way than Erin. He sought to teach others what he had not learned at school: “I looked for my own information and I just became well versed in sex-ed because I’m really passionate about teaching others—especially people younger than me—just because I know how scarce the resources are.”⁶⁰ Self-teaching for the sake of providing knowledge to others is not a form of large-scale organization or an exercise of political power, but it *is* a way to combat being erased from the conversation. Elle similarly attempted to provide education to others in high school, though through a much more formal channel:

I was working with like some leadership program and I wanted to introduce sex-ed in the schools because it was something that everyone felt that we needed but we just didn’t have resources for. And when I was going to do it, I was talking with one of the members of the school board and she was the one who told me that they can’t, the school can’t be affiliated with anything that is not abstinence only. And if I wanted to do it, I’d have to go do it at a community center and not through the school.⁶¹

Unfortunately, Elle’s endeavor was not successful. However, it still represented an admirable effort to resist the status quo while simultaneously working on its terms. Ultimately, the self-education strategies used by informants and their attempts to educate others exemplify forms of every day resistance in the face of persistent oppression and exclusion.

⁵⁸ Interview with Erin, January 2019.

⁵⁹ Interview with Erin, January 2019.

⁶⁰ Interview with Samuel, January 2019.

⁶¹ Interview with Elle, December 2018.

CHAPTER 6: CONCLUSIONS AND SIGNIFICANCE

My research participants' narratives presented a consistent theme of cisheteronormative and exclusionary formal sex and reproductive health education. Encompassed within these narratives were other corresponding themes—such as a delayed ability for informants to conceptualize their own sexual identities due to their lack of exposure to LGBT+ orientations, as well as an absence of positive representation, contributing to the development of compulsory heterosexuality. The SRH education as experienced by my research participants was specifically exclusionary and heteronormative in that sexuality and sexual behavior was presented solely as an act of reproduction. Furthermore, sexual pleasure was an afterthought, if mentioned at all. Sex and pleasure were disassociated further with the sole promotion of condoms as a barrier method, and the failure of the formal education system to address other safe-sex materials. Another important and distinct exclusionary aspect of my research participants' SRH education was the cisheteronormativity of the consent frameworks to which they were exposed, which portrayed acts such as sexual assault and abuse as only occurring between cisgender heterosexual perpetrators and victims; these misleading frameworks functioned to the detriment of my study's informants, failing to prepare them for situations they would encounter in their lives. My findings capture serious problems regarding SRH education's lack of comprehensiveness.

Given the inadequacies of the formal sex education system, questions and hopes might arise about the role of healthcare providers and parents in providing this important education to young people and therefore addressing this gap. Historically, the responsibility of parents to provide their children with sexual and reproductive health education has been controversial; in the United States, most parents think that sex education in middle and high school is important

(Guttmacher 2017), though other parents have opposed such education, usually on religious grounds (Masland 2004). In the context of my study, the role of informants' parents varied, though they were uniform in that they maintained a cisheteronormative perspective, and therefore were of little or no value or a detriment. This is reflective of the possible negative consequences of expecting SRH education to occur at home in the family.

However, given the awareness in public health scholarship that abstinence-only or abstinence-plus educational programs have not been meeting the health needs of the youth in the United States with respect of preventing STIs and unwanted or mistimed pregnancies (Santelli et al. 2017), it might be reasonable to expect that healthcare providers would seek to address this critical gap and offer sex education to adolescents as part of routine healthcare. Yet, participants indicated that medical professionals were surprisingly even less involved than their parents in educating them on sexual and reproductive health.

Taken together, these findings support the argument that the cisheteronormative and exclusive structure of formal sex and reproductive health education, in conjunction with parents and healthcare providers who fail to address this deficiency, amount to structural violence, in that they collectively cause harm to LGBT+ persons by denying them the knowledge they require to maintain health and thrive, and by perpetuating existing inequalities between members of the LGBT+ community and cisgender heterosexual people.

This study also demonstrates that LGBT+ people who experience exclusionary and inadequate access to sexual and reproductive health education when coming of age and realizing sexual and/or gender identities tend to devise their own self-education outside of the existing

structures and institutions. In fact, the most significant source of participants' SRH education were different websites on the internet, alongside other types of media such as fanfiction, television and film, literature and even filmography. Many participants emphasized an interest in the credibility of their sources, though this is something that I could not evaluate without specific examples. Other participants that looked to entertainment (such as pornography and television) to provide them with direction recalled the negative impacts of the stereotypes and characters these types of media portrayed. Regardless, the efforts of my participants to educate themselves on matters about sex and reproductive health can be said to represent forms of "everyday resistance," in that these are techniques utilized by a marginalized community to withstand the oppression perpetuated by exclusionary and cisheteronormative formal SRH education, and lack of education at home or from medical professionals. While resistance through the individualized and informal strategies of self-care and self-education is vital for the ability of the LGBT+ participants in this study to maintain healthy bodies and relationships, it also raises questions about the long-term solutions to the persistent issue of poor or harmful sex education in the United States. In particular, since strategies used by my informants functioned as improvised measures utilized in the aftermath of having been left without the needed sexual and reproductive health knowledge, I question if these strategies are enough. To what degree can these individual and private strategies have an impact on the larger structures and facilitate the development of a more realistic sex education to meet the need of present-day youth?

Contributions to Scholarship

This research contributes to existing knowledge in applied and public anthropology, as well as in other social sciences by providing real-life examples of the negative consequences of

exclusionary SRH education in the United States, and thereby illustrating the necessity of LGBT+ representation in sexual and reproductive health education (Blake et al. 2001; Elia and Eliason 2010; Santelli et al. 2017). These data also expand the notion of resistance in social sciences to offer an example of how structurally oppressive systems also generate strategies in the neglected and marginalized population to overcome or alleviate these challenges (Scott 2008). Therefore, by using the theoretical lenses of structural violence and forms of everyday resistance, my study contributes to an understanding of how macro-level structures inform individual experiences and health, as well as an awareness of how individuals resist structural forces (Farmer 1996; Galtung 1969; Singer et al. 1992).

This project supports the need for additional research on matters that pertain to government policy and reflects the need for other anthropological studies regarding SRH education, a field that has been historically approached by sociological and public health perspectives. This project also lends support to existing advocacy on behalf of students, teachers, and parents, as well as non-profits such as GLSEN, SIECUS, Planned Parenthood, the Human Rights Campaign, Advocates for Youth, the Brown Boi Project, and the Keystone Coalition for Advancing Sex Education. Groups such as these have made strides towards inclusive SRH education. Advocates for Youth, Answer, GLSEN, the Human Rights Campaign, SIECUS, and Planned Parenthood Action Fund released “A Call to Action: LGBTQ Youth Need Inclusive Sex Education,” urging policymakers to remove the legal barriers to LGBTQ-inclusive education, to support funding for comprehensive education, and to provide resources for teacher training, evaluation and research (Planned Parenthood Action Fund 2019). The Keystone Coalition for Advancing Sex Education is in the process of developing a curriculum for student organizations

to educate their peers on sexual and reproductive health and dedicate their efforts to serve students with disabilities alongside LGBT+ students (Keystone CASE 2019). The Brown Boi Project authored *Freeing Ourselves: A Guide to Health and Self Love for Brown Bois* (2011), an inclusive mental, physical and sexual health curriculum for transgender and gender non-conforming people of color.

Future Research

This project could be built upon in many ways—future research might examine how pornography perpetuates negative stereotypes about the LGBT+ community and advocates for unsafe and even harmful sexual practices. Future researchers might also conduct ethnographic research with educators to gain a greater understanding of the barriers they face to implementing inclusive SRH education. Analysis might also be improved by applying a comparative approach, for example, conducting ethnographic interviews with sample populations who experienced sexual and reproductive health education in two states with vastly different standards and policies. Others might address the efforts of advocacy groups to implement a more inclusive curriculum, and how those efforts have impacted policies thus far.

Additionally, other projects may address the need for additional types of representation in formal sexual and reproductive health education, such as the inclusion of disabled people, or by incorporating different cultural perspectives. Such approaches could apply the analytical framework of intersectionality to participants' experiences with formal SRH education. Intersectionality was initially conceptualized in 1989 by civil rights activist and legal scholar Kimberlé Crenshaw to explain how race and sex intersect to create unique experiences of

marginalization for black women, though it can include other social categorizations, such as sexual and gender identity, class, and physical ability.

I hope this Honors-in-the-Major research project will generate new interest and provide the springboard to future research in this area.

APPENDIX A: IRB APPROVAL LETTER



University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Determination of Exempt Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Joanna Zofia Mishtal and Co-PI: Karli Reeves**

Date: **November 20, 2018**

Dear Researcher:

On 11/20/2018, the IRB reviewed the following activity as human participant research that is exempt from regulation:

Type of Review: Exempt Determination, Category #2
Project Title: Experiences of Young LGBT+ Adults with Sexual and
Reproductive Health Education
Investigator: Joanna Zofia Mishtal
IRB Number: SBE-18-14539
Funding Agency: N/A
Grant Title: N/A
Research ID: N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

This letter is signed by:

A handwritten signature in black ink that reads "Kamille Chay".

Signature applied by Kamille Chaparro on 11/20/2018 03:34:19 PM EST

Designated Reviewer

APPENDIX B: EXPLANATION OF RESEARCH FORM

Version 2.0 11-13-2018



EXPLANATION OF RESEARCH

Title of Project: Experiences of Young LGBT+ Adults with Sexual and Reproductive Health Education

Principal Investigator: Joanna Mishtal, PhD.

Other Investigators: Karli Reeves, Honors in the Major Student

Faculty Supervisor: Joanna Mishtal, PhD.

You are being invited to take part in a research study. Whether you take part is up to you.

The purpose of this research is to gain a greater understanding of the experiences of LGBT+ individuals regarding sex and reproductive health education.

Participants will be asked to participate in a verbal interview. The interview may be audio-recorded with the permission of the participant. Any audio recordings created during the interview will be immediately destroyed after a transcript is created and de-identified. De-identified interview transcripts will be stored for up to 5 years per UCF data retention policy. No contact information for the participant will be collected.

The interview will take place at a location convenient for both the investigator and the participant. Interviews may last approximately 20-60 minutes. The participants will be asked to participate in an interview at a time that is convenient for the participant.

Participants must be 18-30 years of age must identify as being LGBT+ (lesbian, gay, bisexual, transgender), non-heterosexual, or non-cisgender.

This interview contains questions that may cause you to reflect on past emotional events. If answering these questions has caused you to experience any kind of distress or made you feel uncomfortable in any way, please contact UCF Counseling and Psychological Services (CAPS) at 407-823-2811.

Study contact for questions about the study or to report a problem: If participant has questions, concerns, or complaints: Karli Reeves, Honors in the Major Student, Department of Anthropology, College of Sciences, (850) 619-6689 or Dr. Joanna Mishtal, Faculty Supervisor, Department of Anthropology at (407) 823-3797 or by email at jmishtal@ucf.edu.

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been determined to be exempted from IRB review unless changes are made. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901.

APPENDIX C: INTERVIEW GUIDE

INTERVIEW GUIDE

Reeves, v.1.1, December 3, 2018

Project Title: "Experiences of Young LGBT+ Adults with Sexual and Reproductive Health Education"
(After Informed Consent)

Thank you for agreeing to talk with me today. My name is Karli Reeves, and I'm an honors anthropology student at the University of Central Florida. In this interview I'm interested in your experiences with sex and reproductive health education. All the information you give me will be confidential – I will not ask you for your name or any information that could identify you. The interview is voluntary, and it will take 20-60 minutes. Can I audio record our interview, or would you prefer I didn't? Would you like to start now?

Research Site: _____
Date: _____ Time: _____

Questions about Experiences and Perspectives

I would like to ask you a few questions about your experiences with sex and reproductive health education.

1. How would you define sexual education?
2. While attending school throughout your life, did you ever receive any education about sex and/or reproductive health?
Probe: Do you remember what grade or school level you first received this education?
Probe: Did you receive this type of education in more than one grade/school level? If yes, do you remember which ones?
Probe: If you received this education, can you approximate for how many semesters?
3. Were you educated on sex and/or reproductive health at a public school, private school or both?
Probe: If both, did sex and/or reproductive health education differ in any way between public and private schools?
4. Was your formal sex and/or reproductive health education part of a specific course's (ie. Child Development, Anatomy) curriculum or was it mandatory for all students?
Probe: If for a specific course, what was the course?
Probe: If for a specific course, do you feel that the curriculum was adequate in addressing any questions you had on the subject?
Probe: If for a specific course, do you feel that you or other students would have benefited from mandatory sex and/or reproductive health education outside of that included within course materials?
5. Were you aware of your sexual orientation and/or gender identity when you received sex and/or reproductive health education?
Probe: Did sex and/or reproductive health education have any effect on your realization of your own sexual orientation and/or gender identity?
Probe: If you didn't receive sex and/or reproductive health education, or if you did and it didn't include/mention LGBT+ identities/orientations, do you think that such a curriculum would have assisted with the realization of your sexual orientation and/or gender identity?
6. Was the formal sex and/or reproductive health education you received sex-segregated?
7. Did you ever receive inaccurate or irrelevant information throughout your formal sex and/or reproductive health education?

INTERVIEW GUIDE

8. Did any of the sex and/or reproductive health education you receive mention the existence of LGBT+ identities/orientations?
 Probe: If yes, to what extent were LGBT+ identities/orientations discussed?
 Probe: If yes, were LGBT+ identities/orientations only discussed in the context of STIs like HIV? How did/does this make you feel?
 Probe: Do you remember which LGBT+ identities/orientations were discussed?
 Probe: If no, were you aware of the existence of LGBT+ identities/orientations?
 Probe: If yes to above, do you remember where or from whom you learned about LGBT+ identities/orientations?
9. If the sex and/or reproductive health education you received mentioned the existence of LGBT+ identities/orientations, do you feel as if the instructor(s) teaching imposed any value judgements/biases about LGBT+ individuals?
 Probe: Did the curriculum itself (physical materials like textbooks, pamphlets, etc.) have any biases toward or against LGBT+ individuals?
 Probe: Did the teacher(s) and/or curriculum ever conflate sexual orientation and gender identity?
10. Did you feel comfortable and/or safe bringing up questions about LGBT+ identities/orientations while receiving your formal sex and/or relationship health education?
11. Did you ever supplement your formal sex and/or reproductive health education with outside information from any source? (Some examples of outside sources are parent(s)/guardian(s), older sibling(s), doctor(s), friend(s), websites, television, etc.)
 Probe: If yes, can you give an example of an external source or sources that you used?
 Probe: What reason would you give for choosing this source/these sources?
 Probe: Did you feel comfortable and/or safe seeking information this way?
12. Can you give any examples of questions that you asked when seeking information from outside sources?
 Probe: Were your questions oriented more towards sex or reproductive health?
13. While seeking information about sex and/or reproductive health from outside sources, did you ever receive inaccurate information?

Demographics:

I'd like to close the interview with a few brief demographic questions:

- a. Age (please state): _____
- b. Gender (please state, as self-identified; give the option of "I prefer to not answer"): _____
- c. Sexual Orientation (please state, as self-identified; give the option of "I prefer to not answer"): _____
- d. Ethnicity (please state, as self-identified): _____

Thank you very much for your time. Do you have anything else you'd like to add that I didn't ask you? [if not:] Please don't hesitate to contact me if there's anything else that you would like to add that you have not had a chance to say during this interview. Here's my contact information: Karli Reeves, Phone: 850-619-6689 (call or text). Email: kmr98@knights.ucf.edu.

APPENDIX D: RECRUITMENT FLYER



Hello! My name is Karli Reeves, and I am an Honors Anthropology student at UCF. I am conducting a research project to gain a better understanding of LGBT+ individuals' experiences regarding sex and reproductive health education!

WHO CAN PARTICIPATE?

If you are 18 to 30 years old, **AND** you identify as being LGBT+ (lesbian, gay, bisexual, transgender), non-heterosexual or non-cisgender, you are eligible to participate!

HOW DO I PARTICIPATE?

If you are interested in participating in this **CONFIDENTIAL** study, or if you have any questions, please do not hesitate to contact me via email kmr98@knights.ucf.edu. Also, feel free to contact my faculty supervisor, Dr. Joanna Mishtal, at joanna.mishtal@ucf.edu.

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