“I THINK HIV IS AN STD?”: ADOLESCENT LIVED EXPERIENCES IN SEXUAL EDUCATION, STD/I KNOWLEDGE, AND THE ROLES OF STAKEHOLDERS IN THE URBAN MID-SOUTH

Kiersten Lynn Bloom

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“I THINK HIV IS AN STD?”: ADOLESCENT LIVED EXPERIENCES IN SEXUAL EDUCATION, STD/I KNOWLEDGE, AND THE ROLES OF STAKEHOLDERS IN THE URBAN MID-SOUTH

by

Kiersten Lynn

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For all the patients who knew they weren’t crazy to advocate for themselves, including myself, and all the medical providers who truly listen.
Acknowledgements

I would be remiss if I did not take the time to thank the crowds of cheerleaders I have had in my court for years. First, the one who has cheered the loudest and longest, my mom. From a very young age you led by example, showing me what education could do for my future. Despite my adolescent push-back, the memory of a strong woman with a full-time job and a five-year-old finishing law school and passing the bar exam to be sworn in as an employee of the Hawaiian Attorney General’s office, persevered. Even though I did not become a lawyer like we thought, I finally have as many degrees as you do and I hope I have become the, “productive member of society,” you raised me to be. I also hope that I have made you proud using my voice to advocate for those who are often silenced. You definitely did not raise a doormat and I am forever grateful that you held space for me to develop and voice my opinions. Thank you for all the times you had to convince me not to quit, and all the times you celebrated my wins. I could not have done this without you. You are the best mom I could have asked for and I love you, always, forever.

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Californian with no idea how different Tennessee would be, you both have changed my life for the better. I would also like to thank my committee Dr. Haught, Dr. Potter, Dr. deVelasco, Dr. Johnson, Dr. Matthews, and Dr. Terui, who both pushed me and supported me throughout this experience, you are the exemplars of what it means to be a teacher. Finally, my foundational professors, Dr. Stitt, Dr. Stoner, Dr. Williams, and Dr. Miller. I think of you constantly and ask myself what you would do in many situations. I hope one day that I earn the right to have my students think of me as highly as I think of you. I would not have gotten to this point without any of you.

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My chosen family. Lindsey, I am so wildly proud of all you have accomplished and I am grateful that we have stayed so close for so many years. It’s fitting that our first friend trip was to Planned Parenthood and now I have dedicated my life to sexual and reproductive health. Look at how far we have come! Kirsten, you and your family accepted me from the beginning and have been nothing but rays of sunshine. I am so lucky to be Ari’s Dr. Auntie K and cannot wait to squeeze you both in person. Alice, I will never be able to thank you enough for deciding we would be friends. Your intellect has ushered me through many academic crises, and your
empathy has prevented me from committing many acts of arson. I have loved learning from you and with you.

Finally, I want to hold space for myself. There is no question that I have devoted literal blood, sweat, and tears to this degree. This degree broke me and it was myself and the communities I cultivated that built me back up. I have always been hard-headed and I will always dig my heels in, but after experiencing every barrier, I truly did not think I would ever see the finish line, despite the cheerleaders who always said they knew I would. I am so much stronger than I think I am and this accomplishment is just the beginning. I did it!
Preface

The first time I encountered sexual and reproductive health information I was in the fourth grade and had just settled in California after a decade of moving every two years with the Air Force. It was in after-school care and a fellow student whispered to me casually as we walking to the restroom that you could get pregnant from a boy putting his tongue in your ear, an obvious farce. Ignoring the fact that I remember this encounter but struggle to recall if I locked my car door this morning, I do not remember my sexual education experience in middle school or high school in California. However, I do remember having the exact same experience as these students who shared their lived experiences with me, 22 years earlier.

I was in 6th grade and was ushered into a dark classroom with the other 6th grade girls from all classes to learn about menstruation. I remember it was standing-room only and the air was sticky with pre-pubescent anxiety. I could not tell you what happened in the video, I likely spent the entire time making faces at my friends, thinking about what snack I would make when I got home, or getting a head start on my homework. I did not encounter a formal sexual or reproductive health course again until high school when I took my required health class as a summer elective, the way I spent most of my summers with two working parents who highly valued education. Ironically, I do not remember the one-unit sexual education element. My primary memory is of a presentation I was required to give on a disease. I selected scoliosis as I had been diagnosed at age 12, and put in a back brace my sophomore year. I remember vividly holding up the x-rays of my curved spine and being self-conscious that people may comment on the non-existent fat that showed up as a faint outline on the image. I could not tell you if we learned about STD/Is, pregnancy, or even anatomy.
What I did not realize or admit to myself as a boy-crazy 6th grader, was that I was also queer. This may be why I have little to no recollection of my sexual education experience, I did not know it at the time, but it is possible that I did not see myself represented in the heteronormative material. This was not the last time I had to suffer the consequences of my lack of sexual education information awareness, or even general health literacy. In fact, this was a common theme throughout my adolescence and my 20s, culminating in a near death experience.

One of the first times I faced the consequences of myself or my parents not knowing how to advocate for my health, or that they needed to advocate at all, was in high school. In middle school, I had a very enjoyable, mandatory scoliosis screening in the girls’ locker room after P.E. class. Surrounded by our peers, we were all asked to remove our shirts and bend over and touch our toes while a medical provider went around looking for signs of scoliosis. Standing there, self-conscious, in only a sports bra, the medical provider behind me started making concerning noises. As my peers who had already been cleared stared, every provider who was present huddled around my arched spine. In retrospect, I know the providers should have taken me into a private area if they had concerns, but at the time I was mortified and had no health literacy or parental advocate present. They informed my parents that I should see a specialist, who then confirmed the diagnosis.

She did not think that it was severe enough to be braced and told my mother to follow up as I grew to ensure the double curvatures did not increase. Being essentially a single working mother who also did not have enough health literacy at the time, this suggestion went by until I was a sophomore in high school. By that point, it was too late for less invasive measures and I was fitted for my miserably uncomfortable back brace. For a year, I fought my parents who would catch me with it off while I tried to sleep at night or when they had to yell at me to get me
to come out of the shower, one of the only places I did not have to wear the brace. I was fortunate to not have experienced direct bullying or social implications due to the brace and my adherence to this solution prevented me from progressing to the point of mandatory spinal surgery. While this was not a life-threatening diagnosis, it was my introduction into the concept of agency and forced me to develop a healthy skepticism of the effectiveness of medical providers. These concepts were reinforced after a scary experience at 19 years old.

During a routine pap smear, my primary care physician found a lesion on my cervix. I was given the test results in an email on a Friday afternoon and could not reach a live human on the phone. In a Dr. Google infused panic that I had cervical cancer at 19, I repeatedly called every department in the facility to try to get transferred to someone who could explain what was happening. Horrified by the lack of responsiveness or empathy to my pleas, I waited for a response and began the downward spiral, imagining my life with cancer. When I was called back hours later, a direct result of my efforts to be active in my own health, I was assured we were not to that point and that the panic was unnecessary. Ultimately, I was referred to a specialist and was told the lesion would need to be biopsied using a procedure called a colposcopy. Unsure what this would entail and still not health literate enough to ask or do my own research, I consented. In 2022, a viral TikTok informed people who had or would have this procedure that it was commonly performed without anesthetic of any kind, information I learned 13 years after my procedure. In addition, I learned that physicians would commonly use a tenaculum to stabilize the cervix. This tool looks like a very sharp, long pair of curved tweezers and would pierce the cervix in two places to steady the area so the biopsy tool could cut out a small piece of the cervix. Even with my low health literacy levels during this time in my life, I would never have consented to having pieces of my body removed without pain medication if I had known it
was happening. But I pushed through the discomfort and was cleared of any potential of cancer. I was told to follow up every six months until I had two normal pap smears. Having learned the importance of following up already, I complied and have received only normal results ever since. This experience amplified the lessons I learned during my scoliosis phase, and solidified the importance of personal agency in healthcare, a lesson that would later prepare me to save my own life.

In 2015, one semester into my M.A., I was working full time as a marketing representative, coaching gymnastics at night, and starting to have severe headaches. For three months I looked for answers in over-the-counter medications, homeopathic remedies, and every doctor who would listen, which unfortunately, wasn't many. I begged for scans, medications, anything that would bring relief. For the most part, I was met with the same response, “You’re just a woman. You’re stressed out, doing too much. Just go home, relax, take a bubble bath, have some wine. It will go away.” But the headaches did not go away. In fact, they increased in frequency and duration. I tried an emergency department but after ten hours of waiting and not being seen, I went home and slept. The next morning I took my usual dose of thousands of milligrams of ibuprofen which I was delighted to be able to hold down until I got to my office, expelling it into the trash can under my desk. I realized there were holes in my vision and began to cry.

The HR manager of the company found me and I finally shared the experience I had been hiding for fear they would fire me from my first real, adult job. Instead, she dragged me to her car and rushed me to a different emergency department where I was scanned, diagnosed, and admitted for transfer to the neurology ICU within 10 minutes. The physician slapped the scan on the wall and explained that he was not sure why we were able to see it on this type of scan,
however, on my left side, near the base of my skull, I had a blood clot attempting to cut off the 
blood supply to my brain. I began to cry and the first words I said as I fought off the nurse 
attempting to place an IV was, “I knew I wasn’t crazy.” Almost as much as I needed relief from 
the pain, I needed the validation that I knew my own body and I knew something was wrong. I 
was told later that the physician said he had never seen someone come into the ED with this type 
of clot and leave.

During my $75,000, week long hospital stay, a week before my 25th birthday, the medical 
providers determined the cause was not genetic, but likely due to an extended period, seven 
years, taking a high dose of synthetic hormones. The birth control pill, Yaz. This is where my 
journey to health communication and sexual and reproductive health specifically took flight. I 
interacted with every aspect of the medical field during this experience and while I had little 
interest in health before, it became all I could think about after. From the organizational 
communication failures such as policies which prevented me from being seen earlier or 
ambiguous billing and insurance protocols that harassed me as I healed, to the interpersonal 
communication barriers of providers who did not listen or believe my pleas, to the interpersonal 
concept of agency, without which, I would not have survived, health communication was the 
unifying theme. As a result, my master’s thesis surveyed women to assess their perceptions of 
risk after viewing an advertisement for the birth control pill. I then moved 2,000 miles to 
Memphis, Tennessee to pursue my doctorate. As I narrowed my academic interests, I attempted 
to identify the point in my life that, if I had been exposed to more effective sexual and 
reproductive health information, would have prevented any of my negative health experiences. 
Sex education was the answer.
In my quest to prevent my experiences from happening to anyone else, I spent seven years in Memphis, where I was forced to experience the Tennessee medical and legal systems firsthand. It is impossible to divorce the influence of the legal system from the policies and level of care, or lack thereof, provided by Tennessee health facilities. Legislation in 2022 includes one of the most restrictive abortion laws with limited exceptions such as protecting the pregnant person’s health or if the fetus is not expected to survive but does not apply to cases of incest or rape as most abortion laws previously allowed. Another recent constraint placed on Tennessee healthcare systems banned all gender-affirming care for minors. In Tennessee as well as many other states, personal medical decisions that should be made under the oversight of medical providers, is being influenced by legal policy. To add insult to injury, the medical systems were tested by a global pandemic. Much like when the New Orleans levees were tested during hurricane Katrina, the medical systems in this community broke as a result.

COVID-19 had a significant impact on medical systems and providers worldwide. In Memphis the implications of this pandemic became visible in the medical provider shortages, extensive wait times to make primary care appointments, emergency department crowding, and medication scarcities. The social determinant of health of geographic location was especially important during this time as this already unhealthy community was now even more susceptible to negative health outcomes. One example of a negative health outcome experienced during the pandemic is chlamydia. According to the CDC, diagnoses of chlamydia fell during the pandemic, but not because people were not having sex. In fact, birth rates actually rose in 2021. The reason there were less diagnoses of chlamydia is due to the fact that this STI is often free of symptoms coupled with a lack of access to primary care appointments as well as a decreased desire to go in public for medical appointments due to the risk of contracting COVID. The number of cases did
not decrease, they were just not being diagnosed at all.

In this dissertation I will share the lived experiences of seven adolescents, much like I just shared my own. It is my hope that we will use their brave admissions to improve medical care in Tennessee specifically and the United States as a whole.
Abstract

Despite high rates of adolescent pregnancy and STD/Is, the state of Tennessee does not mandate comprehensive sexual education courses. Instead, family life education, more formally known as abstinence only sexual education, is only mandated if the pregnancy rate in the county is 19.5% per 1,000 15 to 17-year old’s. While there is significant literature condemning the use of abstinence only until marriage (AOUM) sex education, the outside religious and political influences of the area have prevented necessary sexual and reproductive health information from being communicated to our adolescents. To add insult to injury, restrictive legislation has been passed in 2023 that further restricts especially marginalized communities including the LGBTQIA+ community. This study aims to use the lived experiences of adolescents in the area to inform future sexual education lessons. Through analyzing their current awareness of STD/Is that have high adolescent contraction rates in the area, to understanding the stakeholders who impact their awareness of these infections, future research will be able to better frame sexual and reproductive health information in ways that adolescents desire.

This project employs interpretive phenomenological analysis to explore the lived experiences of adolescents with sexual education content in the urban Mid-South. A snowball sampling method conducted by a local middle school administrator, in order to protect the anonymity of this vulnerable population, returned seven 14-year-old students entering the 9th grade for interviews. Results were categorized into several themes including awkward family discussions, preference for maternal involvement, safe spaces in friend groups, uncertainty and insecurity, and desire for representation. Students desired a more active, inclusive approach to sexual education courses while also being unsure what that would entail.

Keywords: Sexual Education, HIV, Adolescents, Sexual and Reproductive Health
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Chapter One: Introduction

Background

In 2019, the Centers for Disease Control and Prevention (CDC) released the Sexually Transmitted Disease Surveillance Report which included rates of sexually transmitted diseases and infections (STD/Is), noting that rates have increased in the United States for the sixth consecutive year (Sexually Transmitted Disease Surveillance 2019, 2020). The report also highlighted that while all sexually active persons are at risk, young people aged 15 – 24, gay and bisexual men, and pregnant women were at the highest risk for contracting STD/Is (2020). These disparities increase regionally, with the South, as defined by the U.S. Census Bureau to include Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia ("Census Regions of the United States," 2018) accounting for 52% of all new HIV diagnoses ("Geographic Distribution | Statistics Overview | Statistics Center | HIV/AIDS | CDC," 2018) as well as containing nine of the top 10 highest adolescent pregnancy rates by state (Martin et al., 2019).

While the U.S. adolescent birth rate has continued to steadily decline with the 2018 national average being 17.4 births per 1,000 adolescent females between the ages of 15 and 19 years old (2019), rates in some individual states, particularly in the southern region such as Tennessee’s state average of 25.3 births for the same demographic (2019), remain well above the national average. Despite these rates, sexual education courses are not required in Tennessee unless triggered by state code § 49-6-1302 which mandates that family life education programs be taught in public schools for any county with a birth rate higher than 19.5 per 1000 15 to 17-year-old females ("Tennessee School Health Laws," 2018). In 2018 in Shelby County, TN
Chlamydia was 27\textsuperscript{th} on the list of reported cases with 9,724 cases, 1,037.8 out of 100,000 rate per population, and a cumulative percent of 27\% \cite{SexuallyTransmittedDiseaseSurveillance2018}. Of those 9,724 cases, 2,800 were between the ages of 15 and 19 years old \cite{Doan2021}. Comparatively, gonorrhea was ranked 18\textsuperscript{th} with 4,328 annual cases, a 461.9 rate per 100,000 population, and a cumulative percent of 25 \cite{SexuallyTransmittedDiseaseSurveillance2018}. Of those 4,328 cases, 1,092 were between 15 and 19 years old \cite{Doan2021}. Finally, Shelby County had 303 new HIV cases which as compared to the 762 overall cases in TN, means Shelby County accounted for 39.8\% of all TN HIV new diagnoses \cite{AHEAD2018}. Of those 303 cases, 26 were between the ages of 15 and 19 years old \cite{Doan2021}. Despite Memphis, TN being 8\textsuperscript{th} highest on the list of new HIV diagnoses in the United states, STD/I rates currently have no impact on the presence or absence of sexual education courses in Shelby County. This data reflects rates prior to the COVID-19 pandemic as STIs commonly occur without symptoms which made them less likely to be diagnosed during the pandemic.

Additionally, when present, family life instruction curricula is restricted by Tennessee code § 49-6-1304. This law is influenced by political, cultural, and financial powers and prevents teachers from presenting materials that promote “…any gateway sexual activity,” or, “…sexual activity among unmarried students,” and requires that the curriculum, “emphatically promote only sexual risk avoidance through abstinence, regardless of a student’s current or prior sexual experience,” \cite{TennesseeSchoolHealthLaws2018}. This one size fits all style of instruction actively endangers students whose lived experiences are not represented in the context of abstinence only education. Furthermore, if a violation of these codes occurs and a parent or legal guardian decides to take legal action, after a process of investigations by the director of schools and local board, the court can impose a civil fine of up to $500 to the instructor or organization.
plus court and attorney fees ("Tennessee School Health Laws," 2018). In direct violation of President Obama’s 2010 Teen Pregnancy Prevention Program (TPP) guidelines, this educational environment actively restricts instructors from providing medically accurate and age appropriate information (Rubenstein, 2017). In turn, students cannot achieve comprehension, retention, or application of sexual and reproductive health information.

Family life instruction at public schools is also not required to provide information regarding contraception, sexual orientation, or prophylactics. In its place, courses are mandated to stress abstinence, the importance of sex exclusively within marriage, the negative social and financial outcomes of teen sex, and can even include religious values in these materials (Sex and HIV Education, 2020). Instead of meeting students where they are based on their sexual history and adjusting the information accordingly to meet their needs, materials either ignore heterosexual students’ influential sexual and reproductive health experiences such as previous sexual contact, or publicly depict those who do not follow abstinence, as shameful and even disgusting. Students who do not identify as heterosexual are removed from the conversation entirely. A recent article described a Tennessee student’s recollection of their experience with a family life lesson involving a piece of tape being passed around as a metaphor for purity and cleanliness (or the lack thereof if you participate in premarital sex) (Andrews, 2015). Another anecdotal story from a colleague in this region held a similar moral but used a band-aid as a prop instead of the tape.

Yet another stigmatized example came from a 1996 mid-south school lesson plan asking students to “make connections” through conversations with one another representing sexual encounters, all the while one hidden person was infected with an STD/I and was transmitting it to anyone they had a conversation with. The lesson plan warns the instructor to assign
themselves as the STD carrier or carefully select the student who would represent an STD positive person, as to not isolate or single out a student (*Family Life HIV/AIDS Prevention Education Curriculum Grade 9-12*, 1996) noting the existence of STD/I stigmatization, yet failing to alter the lesson plan to include a discussion amending those perceptions or removing the associated shame altogether. In the same set of lessons, students examined the epidemiology of a factual Tennessee outbreak of Gonorrhea, and were told to remember that in this instance, it was a treatable disease but were cautioned with the fear appeal that, “it could have been AIDS,” (1996) an appeal which could cause significant mental distress for a student who has already been sexually active, but who does not have access to STD/I testing.

These narratives and examples depict how official lessons have negatively impacted the attitudes, beliefs, and values of these now adult members of our society by leaving enduring feelings of shame and stigma related to sexual and reproductive health. Adolescents have no control over what is taught in the schools they attend. Adolescents then to turn to other channels for available sexual and reproductive health information including mass media, which often provides inapplicable or inaccurate information (Scull et al., 2014), or social support networks, an influence that also falls short as friends and family recount similarly ineffective or exclusive sexual education curricula from their time in the U.S. education system. While experiences in family life education lessons have been permanently influential and memorable, it is not due to the success of these programs in persuading teens to wait until they are married to become sexually active. Despite programs like family life education, abstinence only until marriage (AOUM), and even comprehensive sexuality education (Shannon & Csete) or evidence-based interventions (EBI), although less available in the region, aiming to prevent negative sexual and
reproductive health outcomes, STD/I rates in the mid-south continue to rise while adolescent pregnancy rates remain above the national average.

Although there is extensive research depicting the shortcomings of AOUM (McGrath, 2003; Paik et al., 2016) (Santelli et al., 2017) or the higher benefits of comprehensive sex education (Goldfarb & Lieberman, 2020; Rubenstein, 2017; Vanwesenbeeck, 2020), there is limited research which aims to reduce the sexual and reproductive health outcomes faced specifically by Mid-South adolescents through improvement of sexual education lessons related to STD/Is. Even fewer studies include adolescent background or perspectives on sexual education experiences despite health literacy and mass communication scholars’ findings that health information needs to be tailored to the target audience (Baker, 2006; Cairo, 2012). The intersections of increased sexual and reproductive health disparities in the Southern region, legal and political restrictions on sexual education curricula, and socially and culturally (mis)informed social support networks has created the perfect environment for sexually transmitted diseases to thrive in the adolescent population of the Mid-South. Addressing any one of these barriers to sexual and reproductive health has the potential to improve the lives of adolescents and adults alike; specifically, sexual education.

Educators, researchers, and policy makers fail to include adolescent lived experiences and perspectives in the discussion and formation of materials intended for Mid-South adolescents while concurrently holding them solely responsible for the negative health outcomes associated with sexual and reproductive health information ignorance including both enduring and temporary STD/Is. In order to create a more effective educational environment, adolescent input must be included in sexual education curricula development in order to appropriately tailor the information to this population. Through the inclusion of adolescent lived experiences and their
perspectives when assessing sexual education materials, the present research aims to give a voice to those directly impacted by these courses and suggest next steps for improving the effectiveness and inclusivity of sexual education courses in the area.

According to phenomenology scholars, the process of interpreting experiences to establish meaning and the associated context influences are crucial in understanding the worldview of a person (Littlejohn & Foss, 2010; Orbe, 1998). This means it is important to know how students learn and include their voices when seeking to explain what would revise the adolescent processes of meaning making. Transformative learning theory’s focus on lasting changes to attitudes, beliefs, values, and behaviors as a result of a person’s vital, life altering experience also fits well in this vein (Mezirow, 1997). However, these processes do not occur in a vacuum. The relational health literacy conceptual model and the health literacy tapestry serve to explore the important intersections of outside influences including misconceptions and unconscious bias and the media and marketplace or the role of caregivers, providers, systems, and communities above and beyond the responsibilities of adolescents. If policy makers do not take these transformative, lived experiences into account as well as the context of the role of other stakeholders and sources of information and act in accordance with present research calling for improved methods of teaching sexual education courses, adolescents will continue to face negative sexual and reproductive health outcomes. More specifically, in addition to temporary and/or lifelong symptoms experienced as an adolescent with an STD/I, this knowledge shapes future sexual and reproductive health perspectives. Thus, this information is necessary to protect all members of the population from contracting STD/Is that, while often curable by antibiotics with minimal symptoms or discomfort, can develop into life altering and even terminal conditions.
Considering the significant sexual and reproductive health disparities faced by adolescents, the queer community, and the south as a geographic location, as well as the severe sexual education policy restrictions informed by cultural, religious, and political influences, there is an arguable disconnect between present health knowledge and behaviors and what is being done to prevent these negative health outcomes. Despite present research confirming the shortcomings of AOUM sexual education lessons and persisting sexual and reproductive health disparities in these populations, there are holes in applicable research which explores the relationship between the information presented and how it is applied to establish meaning that determines lifelong health attitudes, beliefs, values, and ultimately behaviors. This is where the use of communication studies lenses and foundations is vital. From what information is present in sexual education curricula (or not) and how it is organized and delivered, to the information seeking process that occurs online or in social support networks when the presented information is not thorough, to the assessment and application of information found in order to achieve understanding or behavior change, this conversation is best had from a communication studies perspective. The strengths of communication studies and health communication specifically to navigate this educational terrain and speak to the lived experiences which can inform sexual education course improvements fills a gap in present research which if ignored, will continue to perpetuate dangerous narratives that threaten the health and wellbeing of all Americans. An in-depth exploration of the history of sexual education in the United States, the current state of sexual education, and relevant communication theory is necessary in order to accurately bracket researchers and highlight the scope of the present research.
Chapter Two: Literature Review

It is necessary to begin this project by exploring noteworthy historical events such as the AIDS crisis, 1960s counterculture, and President Clinton’s 1996 welfare reform policies in order to explain the current state of sexual education policy and curricula in the U.S.. Through establishing collectively vetted definitions of significant terms including abstinence only until marriage, comprehensive sexuality education, and evidence-based interventions, we can transition to the present study and depict the communication based theoretical frameworks of phenomenological interviews, as well as the relational health literacy model, health literacy tapestry, and transformative learning theory which are needed to appropriately identify the scope of the study. The goal of this literature review is to explore expert knowledge of the topics of this proposed study as well as clarify the influence of theory in this investigation.

Brief History of United States Sexual Education: 1960s to the Present

It is a common misconception that conservative sexual values such as heterosexual couples waiting until they are married to have sex are deeply rooted in United States ideologies and values. The history of sexuality in the United States actually goes through waves of sexual freedom and sexual constraint. As far as sexual education courses in the U.S., arguably the most impactful wave occurred in the 1960s after an extended period of sexual conservativism. In response to several perceived threats to America and American values such as the Cold War, religious and political leaders in the 1970s became increasingly deliberate about the alteration of American ideologies necessary to maintain power within the present systems. Americans reacted differently to the end of the Cold War era and several movements arose including women’s rights movement and the civil rights movement. Other Americans saw these reactions as an active, moral and social attack on the traditional American dream. Claims, events, and policies
which aimed to restrict other perceived threats such as Billy Graham’s McCarthy inspired opposition to homosexuality due to his belief that as sexual deviants, homosexuals could be blackmailed and thus could not ethically perform their jobs (Moslener, 2015), opened the door for policies that would eventually restrict sexual education information. The escalation of individual level discussions to ideological assertions carrying the weight of national security is a common theme in both political and religious rhetoric from that point forward. The ripples from these events can also be found in other movements ranging from anti-gay to anti-abortion. The following details of historical events explain how our country was molded by religious and political ideologies that now limit sexual education information in United States’ public-school classrooms.

**Religious Influences**

Religions commonly hold an ideological value regarding sexual activity and adolescents. Noting that singular congregations and individuals under the guidance of the same religion often hold personal morals and values which differ from these systemic religious position declarations, the focus of this section will be at the ideological level as disseminated by the religious systems. The world saw a decline in both individual religious acts like baptizing children or regular worship and general identity and knowledge of Christian faiths being passed to new generations due to what has now been deemed the 1960s religious crisis (McLeod, 2007). In 1963 around 70% of Americans identified as Protestant or other non-Catholic Christianity (Newport, 2009). At the same time, protestant evangelicalism experienced a significant value shift which led to its strong influence on initial sexual education policies in the U.S.. Seizing the opportunity to promote religious ideologies as a solution to these domestic, social threats to national security
which the “Moral Majority” deemed to be, “…greater than any posed by the Soviet Union,” (Moslener, 2015), a new ideological trajectory was marked.

Under the umbrella of Christianity, Evangelicals like many religions have experienced transformations and resurgences. For the purpose of this project, Evangelical refers to post-revival individuals and organizations who follow the teachings of Jesus Christ, hold scripture to be law, and, “exhibit a desire to move closer to secular values and representational systems in order to assert a nationalist ideology that privileges the values of Evangelical Christianity,” (Moslener, 2015). The practice of preaching the gospel fits in well with the use of these ideologies in the political sphere, specifically as related to the value of sexual purity. The tendency toward sexual purity and the subsequent impact on sexual education in the U.S. was founded primarily in Evangelical ideologies as a result of the more recent Evangelical-Republican alliance which was established in the late 1970s (Moslener, 2015). Like many biblical teachings, sexual purity is the result of various interpretations of bible verses.

Sexual purity is derived from the religious concept of moral purity, or conversely, sexual immorality. Several bible verses are repeatedly cited related to morality and sex. One states, “For this is the will of God, your sanctification; that is, that you abstain from sexual immorality.” (1 Thess. 4:3). Another verse posits, “The sexually immoral . . . will [not] inherit the kingdom of God” (1 Cor. 6:9). Finally we are told, “The body is not meant for sexual immorality” (1 Cor. 6:13), “Flee from sexual immorality” (1 Cor. 6:18), and “We should not commit sexual immorality” (1 Cor. 10:8). Coupled with passages such as, “To the unmarried and the widows I say: It is good for them to stay unmarried . . . But if they cannot control themselves, they should marry, for it is better to marry than to burn with passion,” (1 Cor. 7:8,9), evangelicals preach the common theme that sex within a marriage is acceptable, and often encouraged to populate the
earth, and sex, or even gazing lustfully (Matt 5:28) outside of the institution of marriage is a sin. However, these verses highlight what is sexual immorality, but not what is meant by sexual purity. In this case, sexual purity then becomes synonymous with premarital chastity as a result of its use in the political sphere.

Protestant evangelical organizations in the 1960s rebranded the concept of individual, private, premarital chastity, as a publicly broadcasted piece of an adolescent’s identity (Moslener, 2015). This strategy was used to establish the Evangelical ideology of sexual morality as the only method of addressing cultural crisis and, “…asserting ostensibly biblical ideals of marriage, family, and sexuality as integral to national well-being,” (Moslener, 2015). These messages and relationships expanded outside of traditional church settings and into the secular, public and political domains through the influence of individual politicians as well as affiliated private organizations.

Comprehensive sexual education advocates have voiced challenges to AOUM policies through highlighting the ethical violations of using the perspective of one religious group’s teachings as the “moral majority” to decide the sexual values of the entire country. The dissemination of media messages of sexual purity from Evangelical Christians as well as their use by conservative politicians, blurs the separation of church and state which further complicates the determinations of what is taught in public sexual education courses and who makes that decision. Although organizations such as True Love Waits and Silver Ring Thing (SRT), have lost preference and popularity to similar messages disseminated by mega-churches, the intentions and teachings which infiltrated American sexual education policies through political channels have remained (Gardner, 2011; Moslener, 2015).
As an exemplar, founded in the early 1990s, SRT used modified evangelical models of publicizing teachings by persuading young people who are relatable to adolescents to travel the country and share educational presentations regarding sexual purity and the dangers of rejecting abstinence. In one of their many presentations, often themed in popular media references such as the admired Lord of the Rings films, SRT included a song whose lyrics state, “the world says use a condom, if we told you you’d be fine/we’d be lying to your face, it’s like playing with a nuclear bomb, you could wipe out the whole human race,” (2015). This reveals the core message of the organization which preached purity and repentance as a political ideology (Moslener, 2015). This connection between condom use and national security threats, while directly targeted at American adolescents, depicts the foundations for political leaders to appropriate these messages for use in the political sphere highlighting SRT’s strategic goals to influence sexual education policy beginning with the connection between adolescent sexuality and the end of the traditional American family.

While other religious messages and groups including Catholics also protest the use of any sexual education lesson except AOUM, the significant influence of the evangelical reach is noteworthy. The connection between religious values and nationalism married happily with political conservatives who feared the, “idealized white, middle-class family, free of relational strife, venereal disease, illness, drunkenness, feeblemindedness, infidelity, and other consequences of moral degeneracy” was in danger and identified comprehensive sexual education advocates as a direct threat to the stability of our country (2015). It is significant that evangelical fear was not about sex itself, but about sex outside of the confines of a ‘blessed’ union, which would fly in the face of the traditional American family structure. The use of this rhetoric historically in both religious and political arenas makes it particularly difficult to
identify a singular influence on sexual education policy, but also particularly understandable that there are multiple, powerful, intersecting influences on related and mainstream sexual and reproductive health topics such as birth control, emergency contraception, and abortion.

**Political Influences**

When instituting a paternalistic initiative aimed at the betterment of society as a whole, the government is often asked to determine what course of action is best for the majority such as instituting mandatory seat belt laws in vehicles or the regulation of smoking in public places or around minors. The hope, albeit sometimes naive, would be that these policies were cultivated from a place of equity and inclusion; however, as discussed, the political sphere is not immune to the influence of religious ideologies. Especially from 1960 to the present, primarily conservative and religious leaders employed fear and the discomfort of the transforming American sexual values to rally the masses and regulate political agendas (Irvine, 2004; Jensen, 2010). In 1997, the education director of the Sexuality Information and Education Council (SIECUS), Leslie M. Kantor, highlighted the bias in sexual education policies stating, “there is mainstream sex ed and there is right wing sex ed. But there is no left-wing sex education in America. Everyone calls themselves ‘abstinence educators’, everyone,” (Jensen, 2010). These frames teach sexual education practitioners and policy makers that the path to political support, and by association program funding, is adherence to the aforementioned evangelical ideologies of sexual purity. Historically, there have been several legal precedents and political occurrences which uphold these ideals even in present-day sexual education policy.

While many accounts of legal influences to sexual education policy begin the concept of Welfare Reform with President Clinton, much earlier, and still widespread were the efforts of conservatives in 1969 to combat the sexual education curricula instituted by SIECUS. Due to the
comprehensive nature of these new lessons, conservative parents who could afford to remove their children from the reach of these programs, did so. Others, including Evangelical and Catholic organizations, actively protested the SIECUS policies as “godless, pornographic, and an affront to family privacy,” calling for the removal of government influence on a topic that should fall under parental oversight (Moslener, 2015). These claims were ultimately supported after a formal opposition to the new curriculum in the Anaheim Union High School District went before the school board and received a majority vote (2015). This victory taught political conservatives that the use of moral arguments based in the godlessness of sexual education lessons in the U.S. (2015) could be successful techniques for passing or challenging desired political initiatives.

Another significant occurrence of continued structural support for religious sexual values happened nearly a decade later when the Adolescent Family Life Act (AFLA) was signed by President Reagan as a solution to rising adolescent pregnancy rates (Irvine, 2004; 2015). As conservatives believed the increase in information concerning contraception in public schools was responsible for the rising rates of sexual promiscuity, teenage pregnancy, and abortion, the AFLA cut funding to comprehensive programs, redirecting a third of the funding to AOU M education initiatives and the rest to programs which supported pregnant adolescents (2015). This act was initially supported by liberals as a political deal was struck with conservatives to support family planning clinics if the AFLA was passed, a compromise which was later challenged by a series of cases filed by clergy citing the First Amendment, eventually being overruled by the Supreme Court and additionally appealed by the ACLU (2015). In 1993, the final ruling required that religious organizations who accepted federal funding for AOU M must, “be medically accurate, must respect the ‘principle of self-determination’ regarding contraceptive referral for teenagers, and must not allow grantees to use church sanctuaries for
their programs or to give presentations in parochial schools during school hours,” (Moslener, 2015). This represented some of the first separations between traditional evangelical values and sexual education policies in the U.S..

Finally, widely cited in sexual education literature for the present day impact on sex education curricula, in 1996, Congress and President Bill Clinton, passed the Personal Responsibility and Work Opportunity Reconciliation Act, colloquially known as the Welfare Reform Bill with the primary goal of renegotiating restrictions surrounding welfare benefits (Irvine, 2004; Jensen, 2010). Seemingly unrelated but still included, the act mandated that only AOUM education programs would receive federal funding (2010). While religious organizations rejoiced, secular organizations such as the Reproductive Rights Coalition and Organizing Fund (RRCOF) opposed the act and AOUM programs citing restrictions on poor women’s access to sexual and reproductive health resources as well as additional restrictions on benefits as qualified by women’s reproductive decisions (Nelson, 2003). It is clear that this control of sexual education funding, as determined by legal policy, which directly impacts what students are taught in the classroom, is being informed by religious ideologies and political deals. These historical limitations on curricula have been carried forward to modern policy which is dangerous as students are being protected from information rather than STD/Is or unwanted or unplanned pregnancies and being taught that they do not have reproductive freedom (Solinger, 2007).

Both individually and in conjunction religious and political ideologies have seeped and gushed into U.S. sexual education policy, funding, and curricula. Influential exemplars featured here serve to explain how current lesson plan requirements came to fruition and highlight the notion that despite the goal of sexual education courses keeping all American adolescents safe
and healthy, the methods we utilize to achieve that goal are not representative of most
Americans. In the U.S., the most recent data found 42% of teens assigned female at birth, ages
15-19 and 44% of assigned male at birth teens of the same age category had participated in
heterosexual, penetrative intercourse (Abma & Martinez, 2017). Notably less recent data from
2006 to 2008 showed that 11% of 15-19-year-olds assigned female at birth reported, “any same-
sex behavior,” while 2.5% of assigned male at birth reported, “any same-sex behavior,”
(Chandra et al., 2013). More recent or elaborate data including age or what constitutes first
sexual intercourse for LGBTQIA+ adolescents is not presently available. This data supports the
goal of sexual education to keep adolescents safe and healthy as the timeline for first sexual
intercourse and formal sexual education exposure coincide. The issue in question then becomes
the content of these lessons. Considering the deeply rooted conservative religious and political
values present in U.S. sexual education policy, it is necessary to also identify what present
policies and materials have become ineffective, stagnant, or exclusive in the current research.
Only then can the present study begin to explore adolescent lived experiences and perspectives to
pose suggestions for improvements and the future of U.S. sexual education.

**Religious and Political Ideologies' Effect on Sex Education**

The conservative focus on traditional, religious family values to protect the public at
large and the coopting of these ideologies by political officials to maintain their status as the
hegemonic majority also trickled down to sexual education curricula. A primary example of the
intersection of religious and political ideologies’ impact on sex education is the 1980s AIDS
crisis. The widespread, misplaced fear of sexuality created by inaccurate stereotypes of patient
populations, especially queer and urban minority teens, unknown elements of the disease, and, at
the time, absence of effective treatments or cures served as a basis for purity advocates as well as
conservatives to call for a further embrace of sexual traditionalism (Lord, 2010; Moslener, 2015). While sexual education practitioners opposed these religious notions, President Ronald Regan argued that sex education cannot be value neutral asking, “don’t medicine and morality teach the same lessons?” (Lord, 2010). This, “false dichotomy of morality vs. medicine,” (2010) launched sexual education to the forefront of the larger discussion of sexuality in the United States ultimately leading to the presence or absence, depending on the type of funding received or course being taught, of HIV information in current sexual education courses. This is just one example of the influence of these ideologies on subjects taught in sexual education classes.

Another example surrounds the socially constructed discomfort felt by members of our society when discussing the sexuality of adolescents. Challenging this norm by encouraging that sexual and reproductive health resources be shared with adolescents became a direct attack on the American family. Source after source recalled the, “moral outrage” government officials and private organizations proclaimed toward many of the behaviors of outspoken former surgeon general Joycelyn Elders who frequently broke the norm of sexual silence (Irvine, 2004; Jensen, 2010; Lord, 2010; Tone, 2002). Elders defied this by publicly discussing topics such as adolescent masturbation in addition to persuasion techniques regarding contraception, culminating in Elders making a claim that resulted in her removal, that she would wear a crown with a condom on it if sexually active teens would simply practice safe sex (Irvine, 2004; Jensen, 2010; Lord, 2010; Tone, 2002). Simple discussions of sex or sexual health topics with adolescents violated these hard-established ideologies. Although, these ideologies endure as there are still restrictions on what topics are allowed to be discussed in sexual education curricula.
Critics of comprehensive sexual education cite sexual discussion with adolescents on topics including contraception as the cause of increased teen sexual activity and pregnancies outside the confines of marriage as well as sexually transmitted diseases; and, argue that through the removal of sexual discussions, sexual purity can be preserved (Irvine, 2004). There is currently no credible research which supports these claims, instead the opposite has been found to be true. A 2017 process review found that sexual communication between parents and children does not lead to a sexual debut (Flores & Barroso, 2017). Moreover, when sexual communication is present and adolescents classify these interactions as favorable, they are less likely to be sexually active (Karofsky et al., 2001). Research also highlights that a maternal tone of comfort and responsiveness when discussing sex with adolescents lead to the teen being less likely to become sexually active, promoted remaining abstinent, and increased the age at first intercourse (Fasula & Miller, 2006; Guzmán et al., 2003).

Researchers and AOUM opponents note that the use of silence in sexual education topics, such as the military’s “just say no” campaign, only increase the occurrences of STD/Is (Irvine, 2004) yet, these important topics remain restricted in sexual education policies. In the early 2000s, over one third of schools teaching sexual education courses framed abstinence as the only option before marriage and any mention of contraception must do so in a manner which brought its deficiencies to the forefront (Solinger, 2007). This influence on sexual education sustains as an expert more recently pointed out, “our society remains unwilling to make sexuality part of a comprehensive health education program in the schools and anxious to the point of hysteria about young people and sex,” (Jensen, 2010). The application of these religious and political ideologies like silence over active, open communication, can be identified in other areas of our society as well including topics of death or mental illness. As sex educators continue to advocate
for dialogue and change, the foundations religious and political leaders worked so diligently to lay, begin to crack. Unfortunately, those experiencing the consequences are not these leaders, but the adolescents of our country.

**Current State of Sexual Education**

**Background and Definitions**

In 2019, 50.8 million students attended public schools while 5.8 million students attended private schools across the United States (Bustamante, 2019). There are three primary types of sexual education courses funded in the United States. Abstinence only until marriage (AOUM), comprehensive sexuality education (Shannon & Csete), and evidence-based interventions (EBI) have varied definitions filled with vague terminology and imprecise methods for accomplishing course objectives. In 2018, Shelby County schools received $360,000 from the Division of Adolescent and School Health (*DEDICATED FEDERAL ABSTINENCE-ONLY-UNTIL-MARRIAGE PROGRAMS FUNDING BY FISCAL YEAR (FY), 1982–2019*, 2018). Information on even state level Teen Pregnancy Prevention Program funding in 2018 is not available due to political attacks on the program by the Trump administration in an effort to shift to AOUM programs (*DEDICATED FEDERAL ABSTINENCE-ONLY-UNTIL-MARRIAGE PROGRAMS FUNDING BY FISCAL YEAR (FY), 1982–2019*, 2018). In 2017, Centerstone of Tennessee, Inc, a Nashville based mental health and addiction provider serving 63,000 people per year (*Mental Health and Addiction Services in Tennessee*, 2021) received $2,000,000 from TPPP while the Douglas-Cherokee Economic Authority, Inc. and Le Bonheur Community Health and Well-Being received $999,999 and $1,230,000 respectively in 2017 (*DEDICATED FEDERAL ABSTINENCE-ONLY-UNTIL-MARRIAGE PROGRAMS FUNDING BY FISCAL YEAR (FY), 1982–2019*, 2018). Data was also withheld in 2018 regarding the Tennessee Department of
Children’s Services funding received from the Personal Responsibility Education Program (PREP) (DEDICATED FEDERAL ABSTINENCE-ONLY-UNTIL-MARRIAGE PROGRAMS FUNDING BY FISCAL YEAR (FY), 1982–2019, 2018). In 2017, $962,052 from the Prep State-Grant Program. Finally, the State of Tennessee received $1,418,114 in 2018 from the Title V Sexual Risk Avoidance Education Program (Title V SRAE) (DEDICATED FEDERAL ABSTINENCE-ONLY-UNTIL-MARRIAGE PROGRAMS FUNDING BY FISCAL YEAR (FY), 1982–2019, 2018).

AOUM curricula requires that, above all else, the course promotes abstaining from sexual intercourse before marriage. Social definitions, influenced largely by lessons from religious morals, link AOUM to purity, chastity, and virginity, while federal policy definitions use more clinical, health related terminology to delineate goals as, “[AOUM] teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity” (Santelli et al., 2017). Additionally, in conjunction with state and local funding requirements which add further restrictions, these designations limit what information can and cannot be present in lessons. Commonly restricted information in AOUM lessons include contraception and prophylactics or anything outside of the gender binary with less frequently included information such as actively condemning any queer sexual orientation (Sex and HIV Education, 2018). Health professionals and teachers alike sought medically based alternatives to the incomplete perspectives presented in AOUM lessons such as CSE and EBI educational courses.

Created as an alternative to AOUM, comprehensive sexuality education (Shannon & Csete) differs by featuring information regarding the cognitive, emotional, physical and social aspects of sexuality with the goal of increasing sexual and reproductive health knowledge, skills,
attitudes and values (UNESCO, 2018, p. 16). CSE often features topics of consent, demonstrations of prophylactic use, or how to protect against partner violence which create a more holistic approach to sexual education. Similarly, in 2010 President Barack Obama and his administration implemented the Teen Pregnancy Prevention (TPP) initiative requiring federally funded programs to originate from scientific evidence (Schalet et al., 2014). Unfortunately, the definitions presented for what is classified as evidence are unclear (2014). Nonetheless, the U.S. Department of Health and Human Services who funds these 35 different programs, have noted decreases in teen pregnancy and STIs as well as lower rates of high-risk sexual behaviors (2014).

Current research has denounced AOUM for being ineffective and exclusive calling for other options above and beyond both CSE and EBI methods.

In order to determine which type of sexual education information can or cannot be utilized in a particular school, instructors must look to district standards which are developed by state and federal policy makers. Informed by religious influences and political influences, these policies and the associated funding either restrict or provide access to sexual education information which in turn determines what other sources adolescents may utilize during their sexual and reproductive health information seeking process. These influences consist of anything from stereotypes and misconceptions developed after times of high uncertainty such as an irrational fear of gay males after the 1980s AIDS crisis to the co-opting of religious values like the use of sexual purity to maintain the political (and often economic) power of the traditional American family structure. The historical climate especially of the last 60 years as influenced by these ideologies and events has created an inhospitable landscape for sexual and reproductive health information in education. In light of the religious, historical, and political events ranging from the Cold War and the AIDS crisis, to the Welfare Reform Act, an exploration of youth
perspectives. is merited. To understand adolescent sexual and reproductive health perspectives in this landscape of cognitive dissonance regarding sexual health, purity, and desire, this research will employ phenomenological interviews informed by transformative learning theory, the relational health literacy conceptual model, and the health literacy tapestry (see Section Three).

With rising STD/I and pregnancy rates in the U.S., the success of present-day sexual education programs can be questioned. Researchers suggest that abstinence messages may not be successful for all adolescents, but do have the capacity to delay sexual activity by 18 months (Gardner, 2011). For the same population of pledgers, assigned female at birth (AFAB) persons were found to be more likely to contract human papillomavirus (HPV) (Donadiki et al.) than those who did not pledge (Paik et al., 2016). Concurrently, AOUM education has also been found to be ineffective at preventing teenage pregnancy (Stanger-Hall & Hall, 2011) and a literature review of AOUM programs from 2006-2017 found that these programs threaten fundamental human rights (Santelli et al., 2017) prompting increased outcries from comprehensive sex education advocates. CSE and EBI messages have been found to be more effective at influencing sexual and reproductive health behaviors; however, the disconnect between newly implemented policies, a changing cultural and political environment, and the successful integration of effective and inclusive programs in schools is still too great (Vanwesenbeeck, 2020) to make a notable impact on current U.S. adolescent pregnancy and STD/I rates.

As abstinence from oral, anal, and vaginally penetrative intercourse is the only guaranteed method for preventing pregnancy or STDs, there is an argument to be made supporting the reframing and the inclusion of abstinence messages as an option for American adolescents along with safe sex information. Current research aimed at denouncing AOUM
programs (Rubenstein, 2017; Santelli et al., 2017; Vanwesenbeeck, 2020) is far more common than research proposing tangible solutions to the common limitations of U.S. sexual education programs. Although calls for medically accurate information are present, current themes brought to the forefront of these curricula critiques include the presence of shame and stigmatization and the exclusion of queer perspectives.

**Shame, Stigmatization, and the Queer Community**

Current literature frequently assesses the effectiveness of all types of sexual education curricula by delving into what information is or is not present such as topics of anatomy, HIV and other STDs, contraception and prophylactics, or emotional and relational concepts such as consent or intimate partner violence. Exploration of new or different channels for sexual education information such as mHealth apps and social media (Brayboy et al., 2018; Peskin et al., 2015), or even theater (Taylor, 2020) are also present, although less often. There is a notable absence, however, in research testing how messages are crafted and the types of appeals used. This is particularly relevant to health communication as scholars are concerned with how humans apply meaning to experiences and how that meaning influences health attitudes, beliefs, values, and behaviors.

While persuasion and influence research states that fear, guilt, and shame appeals can be effective as participants want to mitigate the negative emotion and expel it as soon as possible, research also notes it can be difficult to separate the emotions of fear, guilt, and shame for assessment (Duhachek et al., 2012). Alcohol consumption behaviors and smoking cessation are common topics utilized to test these appeals; but, these findings can be extended to sexual education persuasion. Research notes that appeals of shame and guilt are not effective tools for adaptive behavior motivation (such as stopping drinking) especially in populations already
feeling these emotions (Duhachek et al., 2012), yet AOUM lessons often utilize these appeals to deter students from starting or continuing to have sex. Examples include the aforementioned dirty tape or bandage anecdotes as well as the Shelby County family life lesson which confirmed that assigning a student to pretend to have an STD is stigmatizing so the role should be given to an instructor (Family Life HIV/AIDS Prevention Education Curriculum Grade 9-12, 1996). Students recall these appeals well into adulthood but little research confirms if it deterred or stopped students from engaging in pre-marital or unprotected sex. This concept will be explored in the present research using transformative learning theory to guide both the interview protocol and the assessment of participant responses. Arguably, these instances could be categorized as passive shame or stigmatization; however, some current sexual education lessons also actively shame queer persons.

One of the strongest outcries against present day sexual education curricula is the lack of inclusion of LGBTQIA+ persons. While typically entirely ignored, if not actively condemned in AOUM lessons, even comprehensive sexual education programs fail to effectively address members of this community and their specific sexual and reproductive health needs. The sexual purity rhetoric which has infiltrated political perspectives and by association sexual education policies, was constituted in the concept that the white, middle-class, heterosexual, nuclear Christian family is the source of American national strength (Moslener, 2015) (Fejes, 2016) (Whitfield, 1996) making these lessons fundamentally anti-gay and leaving these students without access to accurate, applicable sexual health information. Additionally, the evangelical stance against homosexuality does not negate the existence of LGBTQIA+ persons in the U.S. as well as increasing public acceptance, past 50% of Americans polled in support, as depicted by Gallup research in 2010 (Gardner, 2011). In other words, our society can no longer afford to
associate these religious ideologies with sexual health policies at the expense of the health of the queer community.

Present sexual education curricula is not only ineffective at protecting these students from future negative sexual and reproductive health outcomes, but also can also be stigmatizing as some AOUM lessons even contain erroneous portrayals of queer people. A 2004 study investigating 13 AOUM programs used by 69 organizations in 25 different states contained misinformation that could lead to negative sexual health outcomes (Solinger, 2007). One of the identified errors claimed half of the gay male teenagers in the U.S. have tested positive for AIDS (2007). Similarly, incorrect information in these heteronormative sexual education lessons also occurs. Although one source noted that scientific statistics have been manipulated by both sides to support or challenge the effectiveness of AOUM lessons (Moslener, 2015), the same 2004 study contained myths and inaccuracies ranging from definitions of how pregnancy occurs, to how STD/Is are contracted, and including messages of when life begins (DEDICATED FEDERAL ABSTINENCE-ONLY-UNTIL-MARRIAGE PROGRAMS FUNDING BY FISCAL YEAR (FY), 1982–2019, 2018; Santelli et al., 2017; Schalet et al., 2014; Solinger, 2007). which violates the requirement that AOUM programs maintain medical accuracy.

Considering the lasting social impact of historical events such as the fear of the AIDS crisis, ideologies of silence on topics like adolescent sexuality, the religious inclinations toward sexual purity, and the use of these ideals as political tools to inform policy and determine funding, the constant and controversial U.S. debate over sexual education is less shocking. Researchers note that these historical events have led to a schizophrenic approach to sex education (Lord, 2010). It is easy to see why communication scholars have concluded that sexual education programs which provide straightforward, comprehensive information will face the
most difficulties acquiring approval and federal funding while programs which obfuscate the concepts and utilize ambiguity on sexual topics will be socially and financially rewarded (Jensen, 2010). In turn, the country’s now increased rates of adolescent pregnancies and STD/Is (2010) should have been predictable and preventable.

Researchers have identified that, “rational arguments about the benefits of sex-education programs for underserved populations will only go so far in bringing about change. The way arguments are presented is often more important than the arguments themselves,” (Jensen, 2010). Looking forward, it is not only necessary to divorce these historical influences from present day sexual education policy, but also to consider the most effective method for persuading adolescents to adopt safe sex attitudes, beliefs, values, and behaviors. While some researchers argue that the ultimate goal of AOUM and CSE/EBI sexual education programs is to keep adolescents healthy (Gardner, 2011), others disagree that AOUM is concerned with anything outside of persuading teens not to have pre-marital sex including reducing pregnancy or STD/I rates (Rubenstein, 2017). It is time that our sexual education content and policies come together to represent all American adolescents and reflect the most effective way to promote sexual and reproductive health without influence from parties with alternative agendas. In order to start to achieve this goal, present research seeks to establish a framework for improving individual sexual education lessons through the inclusion of adolescent lived experiences. By conducting phenomenological interviews, we can better understand the interpretations of those at the highest risk for negative health outcomes and lay a foundation for increasing the effectiveness of future curricula.
Theories

Scholars from fields including history, political science, and education have conducted research on the topic of sexual education; however, research on this topic using communication theories and methods are less common. Contradictory to fields which deem communication to be a secondary or antecedent process to cultural or economic factors, communication studies scholars see communication as central to human experience and a social process which, in turn, explains those influences (Craig, 1999). This primary focus on communication provides a unique lens to explore human attitudes, beliefs, values, and behaviors. From media communication technologies like television or social media, to general persuasion and decision making, frequently explored communication concepts develop new significance when applied to topics of health. Schaivo surveyed the work of many researchers to isolate a singular definition for health communication as,

A multifaceted and multidisciplinary field of research, theory and practice concerned with reaching different populations and groups to exchange health-related information, ideas, and methods in order to influence, engage, empower, and support individuals, communities, health care professionals, patients, policymakers, organizations, special groups, and the public so that they will champion, introduce, adopt, or sustain a health or social behavior, practice, or policy that will ultimately improve individual, community, and public health outcomes (Schiavo, 2013).

This active and intersectional approach to research is especially well suited to study sexual education in the United States as policies and funding determine curricula which limits the information adolescents are granted access to as well as the level of information seeking students are forced to do through media and social support networks as a result. Health
communication’s multifaceted nature allows for a more in-depth exploration of the extensive influences on the sexual and reproductive health attitudes, beliefs, values, and behaviors that sexual education courses aim to address. Foundational health communication theories such as Ajzen and Fishbein’s theory of planned behavior or Rosenstock’s health belief model are necessary to assess an individual’s health activity which evolves over the course of their life. Without acknowledgement of the role communication plays in health information seeking and application specifically, scholars are unable to identify a complete picture of both sexual education curricula in the United States and the adolescents these programs seek to inform, in order to evaluate programs’ effectiveness and suggest means for improvement. Additionally, these foci of health communication align perfectly with both an epistemological perspective that seeks to understand how humans know what they know and a phenomenological communication tradition which is concerned with how humans assign meaning to experiences (Littlejohn & Foss, 2010).

In order to compile a list of relevant influences to adolescent sexual and reproductive health perspectives, including adolescent lived experiences is critical. Education research frequently asks epistemological questions like to what extent can knowledge exist before experience? Similarly, in phenomenological thought, Verstehen [understanding], is concerned with clarifying personal experiences through an active process of formulating the meaning of that experience and negotiating between that assigned meaning and the original experience for confirmation, also known as the hermeneutic circle (Littlejohn & Foss, 2010). For this investigation, it will be important to utilize both epistemological assumptions and the phenomenological tradition as a guide to answer the proposed research questions.
**Transformative Learning Theory**

Based in Habermas’ communicative theory, transformative learning theory (Mezirow, 1997) utilizes an interpretive perspective noting that there are no enduring truths and change is constant. This alteration of meaning is classified into two domains of learning (1) instrumental learning which is an empirical-analytical method of learning through task-oriented problem solving and cause-effect assessment, and (2) communicative learning, through discussion of values, ideals, feelings, and moral decisions aimed at comprehension of the intended meaning of others (Mezirow, 1997). This theory focuses on adult learning through the process of revising interpretations of experiences (Taylor, 2008). This can occur as a result of a social crisis such as a death or divorce, or after cumulative interactions resulting in a shift in attitudes toward meaning (2008). Taylor identifies the potential for application outside of higher education noting scholarly interest in life events and the factors that shape transformative experiences including critical reflection, holistic approaches, and relationships (2008). The application of transformative learning theory to both adults and adolescents who have experienced family life or sexual education courses in the United States, although previously unexplored, perfectly supports a phenomenological approach.

For the purpose of this research, transformative learning theory will inform the question protocol for the interviews. Hand in hand with roots in the phenomenological tradition, this theory will serve to guide participants through their wants and needs related to sexual and reproductive health information. While transformative learning theory has not been utilized with adolescents often, with only 143 results appearing in a google search of the terms “communication studies”+“transformative learning theory”+adolescents, instead being applied primarily to adults, which yielded 771 results, the theory is still applicable in this group. The
trend in these 143 results was still that college level undergraduates were the primary participants and adolescent data was not collected (Biber, 2020; Owusu-Agyeman & Fourie-Malherbe, 2019; Tsouvala & Magos, 2016) or focused on teachers who worked with adolescents or parents of adolescents (Carner, 2017; Gorenberg, 2013; Scorgie, 2010).

Adolescents are more than capable of the reflective mental processes necessary to achieve both the classification of a transformative experience as well as the hermeneutic circle. Reflexivity and self-awareness, even at simplified levels, can occur at any age. It will allow space for previously transformative sexual education experiences (positive or negative) as well as prime participants to posit what might be transformative for them in the future. The presence of this theory is not to test manifestation or effectiveness of transformative learning theory in sexual education, but instead helps to bracket the scope of the study and allow further exploration in future research.

Health Literacy Theories: The Relational Health Literacy Conceptual Model and the Health Literacy Tapestry

In order to answer RQ2, the concept of health literacy will be applied to create a foundation for the alternate methods adolescents use to seek, comprehend, and apply sexual and reproductive health information. Health literacy, like health communication, has many working definitions. A 2012 systematic review of health literacy definitions and models isolated 17 definitions and 12 conceptual models which the authors then used to develop a new, integrative conceptual model featuring dimensions from the data (Sørensen et al., 2012). This data included definitions widely used in current research which was particularly useful in exploring definitions for present research. Prominent public health organizations including the World Health Organization, the American Medical Association, and the Institute of Medicine posit definitions
in this collection; however, the focus of the process of health literacy in these definitions is on the individual’s skills, often excluding any outside influential factors or additional stakeholders in the process. A 2021 analysis of 589 studies isolated health literacy as (1) knowledge of health, healthcare and health systems; (2) processing and using information in various formats in relations to health and healthcare; and (3) ability to maintain health through self-management and working in partnerships with health providers (Liu et al., 2020). The third theme makes mention of partnerships with health providers but still fails to include other influential stakeholders. For the purpose of this research, Goldsmith and Terui’s relational health literacy conceptual model (2018) and Parnell’s health literacy tapestry (2014) will be used to establish a complete picture of the intersections that work together to develop and maintain health literacy. These theories explore the concept of health literacy outside of previous foci on patients (or adolescents and students) which is unique as compared to the previously discussed definitions.

Goldsmith and Terui draw from and extend past influential definitions of health literacy to create the relational health literacy conceptual model (RHL). Researchers considered definitions including Baker’s dual domain focus on an individual’s reading fluency and prior knowledge or ability to understand written and spoken information (Baker, 2006) as well as Paashe-Orlow and Wolf’s context sensitive, system and individual negotiations of health literacy (Paasche-Orlow & Wolf, 2007) in the creation of this model. RHL is distinctive from most previous models of health literacy in that the onus of achieving health literacy is not on the patient alone, instead being co-created through a process of involving caregivers, healthcare systems, providers, and communities (2018).

For this model, the shared process begins with patients as we are familiar from other definitions and models noting that patients are responsible for, “navigating the emotional and
practical challenges of illness,” as well as, “helping other stakeholders help the patients” (Goldsmith & Terui, 2018). This can be applied to present research by considering patients to be the students/adolescents who receive the sexual and reproductive health information and care, and face the negative health outcomes we seek to prevent. The next group is caregivers who, “manage the emotional and practical challenges of illness,” in order to, “enhance patient outcomes,” (Goldsmith & Terui, 2018).

The caregiver role in present research would endure and encompass all legal guardians of the student/adolescents responsible for both healthcare and in some regions, expressing permission for the student/adolescent to receive sexual education information in school. The third category is providers who, “coordinate among inter and transdisciplinary health care professionals,” and, “ advance the quality of patient/caregiver/provider interactions,” (Goldsmith & Terui, 2018). For present research, the provider role will maintain the current definition with a special notation that sexual education educators from both outside organizations and school systems are represented here.

Community is the next stakeholder in the health literacy process as communities are responsible for, “integrating culture, illness, and communities for health decisions and management,” and “enhancing the connections between (human) resources and local communities,” (Goldsmith & Terui, 2018). This group is especially applicable to the adolescent in terms of social support from peer groups who help to establish sexual and reproductive health attitudes, beliefs, values, and behaviors, as well as sexually transmitted disease and infection communities if the student/adolescent has already experienced this negative health outcome. Cultural and religious influences discussed in the literature review would also be placed here.
The final category is system. Systems, “create understandable and accessible healthcare,” and, “assist stakeholders to utilize resources,” (Goldsmith & Terui, 2018). Present research has discussed the influential political and legal systems that impact sexual education curricula and school systems would also fall into this category. The relational health literacy model helps to account for the role of social support and interpersonal communication that occurs outside of a formal educational setting in the process of adolescents acquiring sexual and reproductive health information making it a necessary foundational theory.

Similarly, Parnell created the health literacy tapestry as a metaphor. This model breaks health literacy into a visualization where threads (antecedents) and fibers (domains) explore, “…the weaving of life experiences and behaviors with the healthcare system,” (Parnell, 2014). This is particularly helpful when utilizing a phenomenological approach to the present research as well as in conjunction with transformative learning theories, both of which have similar foci. The basic fibers that impact individuals, systems, and providers are (1) oral communication, (2) written communication, and (3) access and navigation (Parnell, 2014). The threads are (1) demographics, (2) previous health experience and knowledge, (3) community support, (4) cultural, spiritual, and social influences, and (5) media and the marketplace (Parnell, 2014). Parnell notes that the skills associated with these threads are, “cultivated, enhanced, or even diminish over time depending upon the life experience and specific context,” (Parnell, 2014). Misconceptions and unconscious bias also crucial to the model in each participating stakeholder. For the present study, the rich data which will be learned from the consideration of these threads and fibers is invaluable. Especially considering the aforementioned cultural, political, and religious influences on sexual education curricula and policy in the U.S., the additional layer of
the role of media or misconceptions and unconscious bias will strengthen the response to RQ2 and cast a wider net of potential intersections and influences.

The additional layers of context provided by transformative learning theory, the relational health literacy conceptual model, and the health literacy tapestry will be vital in order to posit how students are (or are not) achieving comprehension and understanding of school sexual and reproductive health materials (RQ1). This is also necessary in order to collect other channels of information utilized by students such as the media or social support networks to determine where else students are (or are not) accessing sexual and reproductive health information (RQ2).

There is an apparent bias in the influences of religious and political ideologies which now present as restrictive and obfuscated policies and funding of sexual education programs and sexual education information in the United States. The lasting reach and continued use of conservative religious and political ideologies in mainstream, modern educational policies is a product of paternalistic protections for adolescents that ignore the lived experiences and intersecting identities of American teens. Through exploring these lived experiences and the influential contexts they were developed in, recommendations of best practices for future curricula can be made. If curricula and policies maintain their current trajectory, I do not anticipate improvements in teen STD/I or pregnancy rates. The purpose of this research is to help inform alterations to sexual education materials in the United States in order to contribute to a decrease in lasting, negative sexual and reproductive health outcomes for our adolescents.
Current Study

This project seeks answer to following questions:

R1: How do adolescents in an urban mid-south city in the United States understand sexually transmitted diseases and infections (STD/Is) within the context of public-school sexual education courses;

R2: How do influences outside public school education inform adolescents’ understandings of STD/Is in the urban mid-south; and

R3: How can adolescent perspectives inform the redesign of materials, content, modality, and/or delivery of STD/I content in sexual education public school curricula in the urban mid-south?

These research questions seek to explore what is communicated about STD/Is in school and how adolescents come to understand STD/I knowledge beyond the context of formal education. This in turn would shift the ways adolescents assign meaning to these lessons and their sexual and reproductive health attitudes, beliefs, and values which can help to address the health needs, practices, and disparities faced by this vulnerable population. While communication studies often explores the way humans learn effectively through theories like social learning theory or cultivation theory, utilizing the communication tradition of phenomenology and lenses of the relational health literacy conceptual model, the health literacy tapestry, and transformative learning theory will add to the overall body of knowledge by addressing the omission of context and student lived experience in present sexual education course materials.
Chapter Three: Method

Project Overview

In keeping with the interpretivist paradigm, this research actively opposes a singular view of reality, instead acknowledging the influence of a person or group’s personal, subjective view of the world in order to comprehend how realities are constructed and maintained through interactions (Braithwaite & Schrodt, 2014). The purpose of this project is to ascertain adolescent experience and familiarity with topics of sexually transmitted diseases and infections both from formal educational channels and informal social support networks or media representations. In order to limit the scope of the research to a manageable level, the top three STD/Is in Shelby, County will be assessed. In order to maintain the rigor and significance of the project, the top two rates of newly diagnosed STD/Is that are treatable as well as the number one highest rate of newly diagnosed STD/Is that are manageable but not curable will be included. These determinations were made from the available data in 2018 for this geographic anchor. Unfortunately, rates of STD/Is for less common diseases such as herpes simplex virus 2 (HSV2) or genital warts are not presently available. Additionally, CDC rates of HIV are broken down by state rather than county so alternate, credible sources of statistics were located and adapted to fit the categories present in table 1. Available STD rates at the county level include rates for chlamydia, syphilis, gonorrhea, and HIV. For the present study, Chlamydia, Gonorrhea, and HIV will be included. Although age specific information of STD/I rates have been requested from the Shelby County Health Department, the high rankings and cumulative percentages of the included STD/Is are sufficient to support the claim that these STD/Is should be the focus of the prior knowledge section of the question protocol. The information gained from these questions can
then be used to establish a foundation for STD/I lessons that are more inclusive and effective based on the direct needs of those completing the courses.

Table 1

Rates of New STD/I Diagnoses in Shelby County, TN in 2018

<table>
<thead>
<tr>
<th>STD/I</th>
<th>Rank*</th>
<th>Cases</th>
<th>Rate per 100,000 Population</th>
<th>Cumulative %</th>
<th>Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>27</td>
<td>9,724</td>
<td>1,037.8</td>
<td>27</td>
<td>Yes</td>
</tr>
<tr>
<td>Syphilis</td>
<td>49</td>
<td>156</td>
<td>16.6</td>
<td>54</td>
<td>No</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>18</td>
<td>4,328</td>
<td>461.9</td>
<td>25</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STD/I</th>
<th>Rank*</th>
<th>Cases</th>
<th>Rate per 100,000 Population</th>
<th>Cumulative %</th>
<th>Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>N/A</td>
<td>303</td>
<td>762</td>
<td>39.8</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Note. This information was used to determine which STD/Is to include in present research question protocol. Rates taken from the 2018 CDC Sexually Transmitted Disease Surveillance Report and the AHEAD organization for HIV Epidemiology.

* Rank in relation to other counties or independent cities in the United States.

Transformative learning theory will be used in order to design question protocols that effectively target RQs 1 and 3 while RQ2 will be supported by the relational health literacy conceptual model and the health literacy tapestry. The scope of this project is not to emerge on the other side with a complete and generalizable new sexual education curricula. Instead, with a narrowed focus on sexually transmitted disease information and the lived experiences of participants, I will gather background information to lay the foundation for future projects which can be extended to include other topics such as contraception or consent. Looking ahead, I will be able to use these communication approaches, resources, and best practices in order to design and then test improved sexual education. This chapter will explore the desired demographics of participants, participant recruitment procedures, interview protocols, and proposed methods for assessment of results.
Phenomenological Interviews

With adolescent voices omitted from the construction of sexual education materials, utilizing methods that forefront lived experiences to establish a foundation for more effective sexual education courses may seem irrelevant. Modern phenomenology, established by founder Edmund Husserl, acknowledges the process of interpretation which requires that people negotiate between their lived experience and the meaning they assign to that experience in order to create a complete understanding of the world (Littlejohn & Foss, 2010). Prominent phenomenology researcher Mark Orbe adds that people are complex and stresses the influence of social, cultural, and historical life circumstances on this process (Orbe, 1998). Orbe also argues that this method creates a, “discursive space where those traditionally muted voices can be heard,” (1998). The use of interviews to assess these influences and provide a platform for those voices pairs perfectly with the phenomenological tradition. This method’s ability to see intersections and highlight previously ignored perspectives makes it uniquely suited to guide this project.

While critics of this tradition note that it is impossible to understand all the factors which would result in an established meaning (Littlejohn & Foss, 2010), it would be outside the scope of this project to claim to assess all influential factors. Instead, in-depth, phenomenological interviews will be utilized to fill gaps in sexual education knowledge which exist as a result of adolescent voices being silenced while the relational health literacy conceptual model and the health literacy tapestry highlight intersecting outside influences such as the role of healthcare or school systems or the influence of media and the marketplace (Goldsmith & Terui, 2018; Parnell, 2014). As opposed to observations which require researchers to pose generalized assumptions based on patterns, allowing these individuals the opportunities to put their experiences into their
own words creates a more in-depth exploration of sexual education experiences and information seeking. Adding multiple interview sessions only increases both the clarity of the responses and the study’s validity as participants have the ability to confirm or correct responses.

**Participants**

The primary qualification for participants is that they are public school students between 11 and 17 years old residing in the geographic location of the Mid-South as determined by proximity to the anchor of the Mid-South, Memphis, TN metropolitan area. While *Tennessee Health Education Standards* include instruction on sexually transmitted infections (STIs) including HIV/AIDS, beginning in grade 3 (about 8 years old), with additional topics being added in grade 6 (about 12 years old), *Tennessee Lifetime Wellness Curriculum Standards*, like family life education, do not occur until students reach high school during grades 9 through 12 (about 14 to 18 years old) (https://siecus.org/wp-content/uploads/2019/03/Tennessee-FY18-Final.pdf). Participants need to be within this age category in order to be representative of the state’s highest age ranges for teen pregnancies and a portion of the largest group of new STD/I contractions in the state. To ensure participants have received this instruction as well as possess the level of emotional maturity necessary to discuss topics of sexual health in detail, participants should be between the ages of 11 and 17 years old. All biological sexes, genders, sexual orientations, socioeconomic statuses, races and ethnicities, and religions will be accepted in this project. These demographic factors may influence the sexual education participants have currently received or the representations of demographics viewed in these lessons; however, in order to create a foundation for a more inclusive version of sexual education lessons about STD/Is, it is necessary to include the perspectives of those who are excluded from AOUM or traditional comprehensive sexual education curricula. Omitting participants based specifically on
gender, sexual orientation, and religion would only serve to limit the findings. Additionally, it is presently unnecessary to exclude participants based on health literacy levels as this project does not include health literacy level assessment in its scope. The inclusion of different channels of instruction only serves to help answer RQ2 regarding other channels of STD/I information.

Table 2

<table>
<thead>
<tr>
<th>Inclusion Criteria for Phenomenological, In-Depth Interviews of Mid-South Adolescents on Sexually Transmitted Diseases and Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inclusion</strong></td>
</tr>
<tr>
<td>Adolescents Aged 11-17</td>
</tr>
<tr>
<td>Geographic Location: Mid-South*</td>
</tr>
<tr>
<td>Parental Consent Acquired</td>
</tr>
<tr>
<td>Adolescent Assent Acquired</td>
</tr>
</tbody>
</table>

*Mid-South determined by proximity to Memphis, TN metropolitan area.*

Setting and Recruitment

An urban mid-south city in the United States will serve as the setting for participant recruitment. This geographic location is required by state law to offer abstinence only sex education or family life curricula and faces higher than average rates of adolescent STD/Is in addition to being representative of other urban cities in the area in terms of size and demographics. As a result, it will be an effective population to sample, although experience in AOUM classes is not an inclusion criteria. I will recruit participants using snowball sampling through the University of Memphis Campus Middle School. The social support networks of school-aged children typically include other school-aged children from current and past educational or extracurricular interactions will aid in the recruitment process. As minors under the age of 18 are a protected, vulnerable population with special protections in human subjects research, using the CITI Program definition, parental consent is paramount.
First, I will design recruitment images to share the inclusion criteria with potential participants and their legal guardians as well as provide instructions to contact researchers for more information through the University of Memphis Campus School.

It is expected that the university IRB will require an assent form signed by the adolescent in addition to a parental consent form. If they adolescent does not consent to the research, they will be released from the sample. These documents will be electronically, securely emailed in PDF format to both the participant and their legal guardian for signatures such that all informed consent documents are transparent and downloadable. The inclusion of both the adolescent and primary guardian’s email address will also help protect against forgery of parental signatures. These forms will help to safeguard this vulnerable population while also assuring participant anonymity such that they feel comfortable sharing personal details of their sexual and reproductive health behaviors without fear that this information will be discussed with their legal guardians. For this reason, legal guardians will be asked to leave the physical room during interviews. This setting and recruitment method will serve to seek explanations for study RQs.

Procedure

After participants are recruited and adolescent and guardian consent is achieved, participant interviews will be scheduled face to face. After verification of parental consent, these in-depth interviews will begin with a background questionnaire to assess relevant participant social determinants of health and lifestyle before making inquiries about [1] the influence of formal, public-school education, social support networks, and media on awareness of STD/I information and, [2] present current examples of STD/I information to participants for participant interaction and critique. The question protocol is present in Appendix A and is a modification from two phenomenology projects (Damico, 2004) (Kennedy-Reid, 2012).
Interview one will focus on the background questionnaire, specific STD/I awareness, and personal experience. Interview two will focus on the transformative nature of those experiences and current/future health attitudes, beliefs, values, and behaviors. Each interview is estimated to last between 45 minutes and an hour. It is necessary to conduct two interviews in order to contribute to the hermeneutic circle (Littlejohn & Foss, 2010) and give participants opportunities to fully explore the meanings they have created through the interpretive process as well as establish the principle of reflection within transformative learning theory (Mezirow, 1997). This will also add a layer of confirmation of participant responses which only serves to add further rigor to the study. If participants are non-responsive or miss the second interview, the participant will be removed from the data set.

Incentives in the form of gift cards as compensation for their time will be offered to participants in an effort to foster reciprocity for this community. Data will be de-identified and stored for two years. After a period of two years, data including informed consent documents will be permanently deleted or shredded.

**Data Analysis**

After data is collected in the interviews, I will transcribe the data and deidentify participant information, replacing names and references with pseudonyms chosen by the participants. Interview one and interview two will be treated as a complete data set for each participant. In order to determine prominent themes from the data, I will utilize interpretive phenomenological analysis (Arthur et al.). The goal of IPA is to acquire a participant's perspective about a specific topic (Smith et al., 1999). This primary aim is in line the interpretivist paradigm used by the present research which rejects a singular, objective view of reality. IPA also highlights the difficulties with acquiring these individual perspectives as
thoughts are not transparent; however, researchers posit that the use of an analytic process when managing the data from semi-structured interview transcripts can make claims about these thoughts (Smith et al., 1999). Smith details the steps necessary to perform an IPA while noting that there are many methods for doing a qualitative analysis and IPA only represents one method (Smith et al., 1999). This process is detailed and visualized below.

Once all interviews are completed and transcribed, the in the IPA process is to read and reread the transcript making notes in one side of the margin if data strikes as interesting or significant (Smith et al., 1999). The rereading and reflecting process is necessary to become intimate with the data. During this process, the opposite margin will be utilized to identify potential theme titles and key words from the text (Smith et al., 1999). These preliminary notes will then be extended on a new sheet of paper to identify connections from the initial themes and key words (Smith et al., 1999). Finally, these refined themes will be formatted into a table using a coherent order and extra attention to identifying these themes in the transcript rather than having origins in potential researcher bias (Smith et al., 1999). Smith cautions that some themes may be informed directly by the question protocol while others will be innovative and original (Smith et al., 1999). This chart of the major themes will be added to the appendices for use in the results section before transitioning to my discussion of the implications of said themes on suggestions for future research and design of sexual education courses. A full representation of the interview protocols which will be utilized to begin data collection for this process are in appendix A and B.
<table>
<thead>
<tr>
<th>Interpretive Phenomenological Analysis</th>
<th>Transcriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1:</strong> Significant or Interesting Information Notes</td>
<td>Participant 1</td>
</tr>
<tr>
<td></td>
<td>Interview 1</td>
</tr>
<tr>
<td></td>
<td>Interview 2</td>
</tr>
<tr>
<td></td>
<td>Participant 2</td>
</tr>
<tr>
<td></td>
<td>Interview 1</td>
</tr>
<tr>
<td></td>
<td>Interview 2</td>
</tr>
<tr>
<td><strong>Step 2:</strong> Potential Themes and Key Words</td>
<td>Continued…</td>
</tr>
</tbody>
</table>

**Step 3:**
Preliminary notes and themes combined and refined

**Step 4:**
Table of themes and examples created in APA format
Chapter Four: Results

This study employed Interpretive Phenomenological Analysis (Arthur et al.) to analyze transcriptions from 14 interviews conducted with 7 student participants. After the data was collected, transcribed, and cleaned, initial interviews were examined for all participants, beginning with participant one. Then, the second interviews were analyzed for all participants. Finally, this method was repeated beginning with interview one participant one again. The first analysis focused on the content present in each student’s lived experiences, the second interaction with each transcription identified similar or repeated narratives and categorized them into themes until saturation was achieved. In the results that follow, I describe five themes from the data that emerged after using interpretive phenomenological analysis, including: 1) awkwardness in family discussions, 2) strong preference for maternal involvement, 3) safe spaces in friend groups, 4) desire for representation, and 5) uncertainty and insecurity. It is first necessary to explore the student demographics, family structures, community memberships, and exposure to symptoms in order to offer my integrated perspective on the lived experiences of these students through the lens of their own narratives.

Profiles

In order to protect the confidentiality of these minors, limited participant demographics will be described. The following section serves as an introduction for each student participant. There is more detailed information proceeding the student profiles to gain a more in-depth picture of their lives and what has influenced their lived experiences.

Bill

Bill is a 14-year-old male entering the 9th grade. He is white and has an iPhone 13 making him assumingly upper middle class. He lives with his mother and step-father, who
picked him up directly from the interviews. He has a relatively large extended family and participates in musical activities outside of school. His demeanor was reserved but he was very receptive to prompting. Bill was the first interview and his reserved demeanor may have been as a result of my own nerves. It was necessary to remember to use altered tone and vocabulary when speaking to adolescents as opposed to speaking to adults and college students which had been my norm for several years. His second interview seemed more comfortable, though I do not question his honesty or openness from either interview.

*Mack*

Mack is a 14-year-old male entering the 9th grade. He is white and has an Android Galaxy making him assumingly middle class. He lives with his mother and father, who picked him up directly from the interviews. He has a relatively large extended family. Due to scheduling issues as well as an error in recording, I am unsure what activities Mack participates in outside of school. He was apologetic for the delay between the first and second interview and appeared committed to completing his commitment. His responsible and respectful nature was apparent. Mack was relaxed and informal in his communication style, but also polite and warm. As my second interview, it was easier to get into the flow of the interview protocol with Mack who provided thoughtful and honest responses.

*Lindsay*

Lindsay is a 14-year-old non-binary student entering the 9th grade. They are white and has an iPhone 11+ making them assumingly upper middle class. They live with their mother and siblings, who picked them up directly from the interviews. They have little to no extended family and participates in sports and computer games outside of school. They immediately self-identified as a member of the LGBTQIA+ community, though I did not ask if this was as a result
of their gender, or sexuality, or both, and appeared relieved when I shared that my partner, now spouse was also non-binary. Lindsay was one of my favorite students to interview. They were inquisitive, personable, and well-informed, although their confidence in their responses did waiver that at times. They were unapologetically themselves and appeared to feel comfortable with both the space and the topic. Throughout the interview, they brought up concepts I had not considered which made a significant contribution to this research.

Sam

Sam is a 14-year-old female entering the 9th grade. She is multi-racial and has an iPhone 8+ making her assumingly middle class. She lives with her mother, father, and siblings, who picked her up directly from the interviews. She has little to no extended family and participates in sports as well as crafting activities outside of school. She self-identified as a very anxious person so I shifted communication styles to foremost empathy and compassion, specifically with question delivery and transitions. I also left additional time for her to think and took extra opportunities to assure her she was doing well and in a safe space. When she took the time to breathe and reflect, she was able to give insight into her opinions with ease and provided relevant responses and detailed examples.

Owen

Owen is a 14-year-old male entering the 9th grade. He is black and has a Samsung cellphone but could not remember the model, based on other context clues I am qualifying him as upper middle class. He lives with his mother, who picked him up directly from the interviews, even accidentally interrupting his first interview. He has a large extended family and participates in many activities including sports and church as well as solitary activities outside of school. Owen was one of the more personable and easy-going students. He seemed relaxed, confident,
and well-adjusted. His responses were immediate and delivered with ease and enthusiasm. When he was unsure, he asked questions and was receptive to additional prompting. His interviews were some of the longer recordings and his perspectives were clear and self-assured. Not only did Owen seem to want to learn, but he also wanted to do a good job for the benefit of others through this research.

Putt

Putt is a 14-year-old male entering the 9th grade. He is white and has an iPhone 11 making him assumingly upper middle class. He lives with his mother, who picked him up directly from the interviews. He has a medium-sized extended family and participates in sports as well as music activities outside of school, with a particular interest in history. He was very self-assured and held to his convictions. He was conscious of his surroundings and apologized for fidgeting. He took advantage of the fidget toys that I provided as well as my offer to move about the interview space freely. Putt did not require much additional prompting and responded to each question almost immediately with his first reaction.

Bee

Bee is a 14-year-old female entering the 9th grade. She is white and has an iPhone X making her assumingly upper middle class. She lives with her mother and siblings, though I am unsure who picked her up as she interviewed before class and did not mention a ride. She has a medium-small extended family and participates in sports as well as video games outside of school. Bee’s demeanor was somewhat closed off. Her incentive to participate may not have been to add to the body of knowledge or help others, instead she may have been motivated by the gift card incentive. Through additional prompting she opened up and began to share her interests.
She was confident in her convictions but often unable or unwilling to elaborate on why she believed what she believed.

The next section will build on these student profiles as well as introduce the important stakeholders in their lives in order to create a more holistic view of the contexts that influence their sexual and reproductive health attitudes, beliefs, values, and behaviors.

**Relational Health Literacy Stakeholders**

Goldsmith and Terui’s Relational Health Literacy Model (RHL) (Goldsmith & Terui, 2018) provides me with a contextual backdrop upon which to build an integrated perspective described by students through repeated interviews. The following is an extraction of RHL in order to contextualize participant narrative. I use the RHL categories of students (patients), parents/extended family (caregivers), medical professionals/teachers (providers), friends/cultural groups/spiritual communities (communities), and laws/healthcare systems/educational programs (systems) to best label the communities that influence these adolescents.

**Students (Patients)**

This section serves as an introduction to the students’ demographics as well as a preview into the communities that support them. All seven students were 14-years-old and entering the 9th grade during their first interview. A visual representation of the student demographics can be found in Table 3. Students were asked to self-identify all demographics including their gender and race. Five students are white, one is multi-racial, and one is Black. Four students are male, two are female, and one is non-binary. To assess socioeconomic status, researchers asked what type of cell phone the students owned. All students had smartphones estimated to have been released in the last five years; five iPhones, one android, and one Samsung. Although there were
no efforts taken to control participant diversity, I was mostly pleased with the balance of perspectives the students had as related to their demographics.

Table 3

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Age</th>
<th>Grade</th>
<th>Gender</th>
<th>Race</th>
<th>Cell Phone</th>
<th>Sexually Active</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill</td>
<td>14</td>
<td>9th</td>
<td>Male</td>
<td>White</td>
<td>iPhone 13</td>
<td>No</td>
</tr>
<tr>
<td>Mack</td>
<td>14</td>
<td>9th</td>
<td>Male</td>
<td>White</td>
<td>Android Galaxy</td>
<td>No</td>
</tr>
<tr>
<td>Lindsay</td>
<td>14</td>
<td>9th</td>
<td>Non-binary</td>
<td>White</td>
<td>iPhone 11+</td>
<td>No</td>
</tr>
<tr>
<td>Sam</td>
<td>14</td>
<td>9th</td>
<td>Female</td>
<td>Multi-racial</td>
<td>iPhone 8+</td>
<td>No</td>
</tr>
<tr>
<td>Owen</td>
<td>14</td>
<td>9th</td>
<td>Male</td>
<td>Black</td>
<td>Samsung</td>
<td>No</td>
</tr>
<tr>
<td>Putt</td>
<td>14</td>
<td>9th</td>
<td>Male</td>
<td>White</td>
<td>iPhone 11</td>
<td>No</td>
</tr>
<tr>
<td>Bee</td>
<td>14</td>
<td>9th</td>
<td>Female</td>
<td>White</td>
<td>iPhone X</td>
<td>No</td>
</tr>
</tbody>
</table>

All students self-reported that they were not sexually active, which was defined for them as including oral, vaginal, or anal touching, manipulation, or penetration. They also claimed they had never contracted a sexually transmitted disease or infection. One student shared that they have current access to both birth control pills and condoms, while two others shared that their mothers specifically offered contraceptives (birth control or condoms) under the condition that the student actively request them, rather than keeping them on hand. When asked why they made the decision to abstain from sexual activity until this point, students shared not only a lack of interest or a consenting partner, but also fear of the potential risks. One participant said,
I feel like I'm too young, and also like it's scary…Just like anything that could happen and I don't know much about it. I know general things…but I don't like know much. Yeah, that's really terrifying.

One student also expressed concern for their future stating,

…Cause I know I’m very engaged and I know there’s a lot of risk like I could get a girl pregnant or something…I don’t want that. Cause I’m not gonna have to take care of the baby and school. I don’t have the money for that.

All students’ tones and non-verbal communications suggested that they were telling the truth; however, it is important to note that despite assurances of anonymity, students could have lied as an identity management strategy or in fear of the information not staying anonymous. I asked the students who said that they were too young or mentioned something about “the right age” what age it would be appropriate to have sex? Overwhelmingly they agreed it was acceptable for sexual contact to begin at 17 or 18 years old. Only one student mentioned that fear of repercussions, assumingly from their parents, if they were to engage in sexual activity before then. He stated, “I’m too young and I don’t trust myself and I feel like I can get in a lot of trouble and it’s just not worth it.” Variance in family structure and active participation in the lives of the students may account for this response.

Parents/Extended Family (Caregivers)

Students were asked to identify immediate family members that live in their direct household presently as well as extended family members including family they may not interact with as often but would still consider family. Students were encouraged to include chosen family members based on these definitions which allowed students to share social influences that were not blood relatives but still members of the family. Interestingly, four of the seven students did
not have siblings; however, the three students who did have siblings had three or more siblings. All students identified a mother or mother figure in their family structure, but only four students disclosed a significant relationship with a father or father figure. These active relationships were not deliberately verified; however, six of the seven participants mentioned they were being picked up personally by a parent at the end of at least one interview. Four students listed large extended family structures including grandparents, aunties, and/or cousins while one did not share any extended family connections. A visual representation of family structures is listed in Table 4.

Table 4

<table>
<thead>
<tr>
<th>Participant*</th>
<th>Immediate Family</th>
<th>Extended Family</th>
<th>Parent Pick-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mother, Step Father</td>
<td>Grandmother, Step Grandmother, Aunts, Uncles, Cousins</td>
<td>Y</td>
</tr>
<tr>
<td>2</td>
<td>Mother, Father</td>
<td>Grandmothers, Grandfathers, Aunts, Uncles, Cousins</td>
<td>Y</td>
</tr>
<tr>
<td>3</td>
<td>Mother, Sister, Brother, Sibling</td>
<td>Grandmother</td>
<td>Y</td>
</tr>
<tr>
<td>4</td>
<td>Mother, Father, Sisters, Brother</td>
<td>Cousins, Aunt, Grandfather, Mother’s Best Friend</td>
<td>Y</td>
</tr>
<tr>
<td>5</td>
<td>Mother</td>
<td>Father, Grandmother, Grandfather, Uncle, Aunts, Grandmother, Aunt, Uncle</td>
<td>Y</td>
</tr>
<tr>
<td>6</td>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Mother, Brothers, Sister</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Family structures are not matched with the participant code name or number and have been entered into this table at random to protect student anonymity.

Parental backgrounds, employment, or reasoning for enrolling students in this school specifically were not assessed but may be useful in developing a better picture of students’ home lives future research. This was an oversight as well as difficult to negotiate while also maintaining student and family privacy. The topic of switching schools or going to a different school than their friends after elementary school was offered by a few of the students but details were not requested or given.
Medical Professionals/Teachers (Providers)

Three students shared that they do not have a primary care physician or medical provider that they see regularly. One student stated that their parent thought they were, “too old to have yearly check-ups,” while others were in transition from a pediatrician to an adolescent or adult provider. One of the more open participants shared,

[I will talk to my doctor about sexual and reproductive health] if it is necessary. When I go to get my physical for sports the doctor will check my penis and ask if it’s been feeling okay. If I have been sexually active with it and stuff like that. And [recommend] to be careful.

Another student without a current medical provider imagined,

I have these questions where I'm just like, I should probably talk to somebody personal, but also that it's smart enough to answer my question. I feel like I want to introduce the topic. I'm just like, can I write on a sheet of paper everything that I'm questioning . . . ?

This student was eluding to the fact that they may not feel comfortable bringing up these conversations with their medical provider and alluded to credibility being important during the information-seeking process. Envisioning future sexual and reproductive health conversations with medical providers, a student echoed feeling uncomfortable asking about these topics while also wanting a trustworthy source of information stating,

I get too scared to ask people I know did it, so I just kind of hide it away, so I guess someone like I trust really well, there's someone I know will help me out without judging . . .
The desire for a written communication option was also expanded to include the classroom and another category of providers, teachers. Only two participants identified one or more current teachers at this particular middle school that they trust or enjoy. When asked what would make it easier to discuss sexual education topics with teachers, one student said,

... [a] more personal connection. There are some teachers that I’ve never talked to about it but there are some, like one...she was really nice...also from [redacted for privacy]...so I guess I would talk to her about it if I needed to.

Another student feared judgement and thought it would be, “weird to talk to teachers about that kind of thing.” The desire students had to only engage in these conversations with teachers and medical providers out of necessity did not occur often enough or to be a theme. In addition, the students did not seem as enthusiastic or talkative in this line of questions. It is still noteworthy because advocates for AOUM sex education call for the parents to be the primary source of sexual and reproductive health information while advocates for comprehensive or EBI sex education consider teachers to be a credible source; however, these students did not. More information is needed to determine if this is as a result of not having a formal sex education course yet, or if students will never feel comfortable including teachers or doctors in this process. This way researchers could determine if a different kind of resources like peer educators would be a better use of sexual education advocacy efforts, or if there is a way to remove the barrier to communication with teachers and doctors for these students. When asked about their ideal sexual education course, a section that occurs later in this document, students all shared that the ability to email their sexual education instructor privately or having access to an anonymous questions box would encourage them to open up more. This suggests that all hope is not lost for this group of stakeholders.
Friends/Cultural Groups/Spiritual Communities (Communities)

All seven students identified highly involved, strong relationships with their friends at school. Five of the seven students played at least one sport. Other community memberships included crafting groups, music groups, and/or the queer (LGBTQIA+ community). Only one student had no outside community memberships and only one student was heavily involved in a local church. Considering that Tennessee is part of the region known colloquially as the bible belt, it is interesting that this group of students was not actively or passively involved in religious practices or institutions. It is possible that more politically conservative or religious households declined to allow their adolescents to participate due to the topic of this research.

Table 5

<table>
<thead>
<tr>
<th>Participant</th>
<th>Community Memberships</th>
<th>Other (Individual) Hobbies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Music School</td>
<td>Drums, Keyboard</td>
</tr>
<tr>
<td>2*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>LGBTQIA+, Soccer, Volleyball</td>
<td>Minecraft</td>
</tr>
<tr>
<td>4</td>
<td>Volleyball, Track</td>
<td>Crafting</td>
</tr>
<tr>
<td>5</td>
<td>Basketball, Soccer, Track, Church</td>
<td>Walking</td>
</tr>
<tr>
<td>6</td>
<td>Soccer, Track, Choir</td>
<td>Video Games, History</td>
</tr>
<tr>
<td>7</td>
<td>Soccer, Basketball</td>
<td>Video Games</td>
</tr>
</tbody>
</table>

* One participant was not asked this question due to an interruption error.

All students described a current contentment with the amount of sexual and reproductive health information within these communities. For students who do not want to have sexual education conversations in these spaces, they do not, for students who did want to have open discussions, they did. A student remembered a conversation had with teammates sharing,

. . . we can't really give you a sex ed class 'cause we don't have your parents’ permission, but . . . Don't do weird things. Yeah, don't do weird things and don't get STIS, don't do bad stuff like that kind of thing.
This narrative was oddly reminiscent of the scene in the film, Mean Girls, where the physical education teacher was instructing a sexual education course and told the students not to have sex because they would get pregnant and die, then ending the discussion and passing out condoms. However, it appears that this brevity was not resented by the students as neither group wished to expand on the frequency or depth of information shared in these groups. One student shared, “It’s just not the place [for those discussions.]”

**Laws/Healthcare Systems/Educational Programs (Systems)**

Three of the students mentioned an awareness of laws that may impact sexual education courses, but no students were able to identify who is in charge of creating sexual education materials citing “lawmakers” or “teachers” as the individuals responsible. No students had regular involvement with healthcare systems, instead citing educational sources like an anatomy course or the internet as sources of sexual or reproductive health information.

None of the students had experienced a formal sexual education course given through the public-school system or an outside organization; however, four students recalled being separated into groups by gender around fourth or fifth grade and watching one or two videos about anatomy, biology, or puberty. In order to ascertain what was taught in these courses or what was recalled by students, the Guttmacher Institute’s Content Requirements for sexual education classes was used as a guide. Students recalled contraception (2/4), abstinence (2/4), the importance of sex only within marriage (2/4), sexual orientation (2/4), negative outcomes of teen sex (3/4), HIV (2/4), condoms (3/4), gender roles (1/4), healthy relationships (0/4), sexual decision making and self-discipline (1/4), refusal skills and personal boundaries (1/4), consent (3/4), and dating and sexual violence prevention (1/4). This information is available in Table 6.
Table 6

Self-Reported Participant Recollection of Content in Anatomy/Puberty Courses

<table>
<thead>
<tr>
<th>Topic</th>
<th>Present</th>
<th>Not Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraception</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Abstinence</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>The Importance of Sex Only Within Marriage</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Negative Outcomes of Teen Sex</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>HIV</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Condoms</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Gender Roles</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Healthy Relationships</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Sexual Decision Making and Self-Discipline</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Refusal Skills and Personal Boundaries</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Consent</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Dating and Sexual Violence Prevention</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

All four students gave the caveat that these experiences were long ago and they were having trouble recalling everything they learned. Healthy relationships were not discussed at all, though was one of the most requested topic for a future sexual education course. The topics that were most commonly discussed included negative outcomes of teen sex, condoms, and consent.

Apart from these four students, one student did not recall watching a video in school but did locate sexual education videos online on their own. This student was exposed to information about abstinence, the negative outcomes of teen sex, HIV, condoms, gender roles, sexual decision-making and self-discipline, and consent.

Considering the Guttmacher Institute’s general requirements for sex and HIV education, students felt that their experience was mostly medically accurate as related to the basics of puberty and would trust that information. One student noted that their physical education teacher, who was in charge of playing the video, cast doubt on some of the topics stating that the students did not have to follow a specific part of the video. This made the student question the credibility
of the information and call for it to be updated. Students classified their experience as both having too much and not enough information for their age at the time but did not find any instructor bias, likely due to the instructors not being responsible for creating the videos. One student did note that one perspective, abstinence, seemed to be presented exclusively. None of the students recalled any mention or promotion of religion.

Reactions to these experiences ranged from more informed to, “a little confused,” to anger since, “it was boring,” to thankful they were exposed before it happened, to “I didn’t feel like I learned anything. I felt like I wasted time. I didn’t feel like I was gonna carry that information with me or anything.” Two male students remembered at least one other time that they interacted with sexual and reproductive health information apart from these videos during a museum trip and a family discussion respectively. Five students shared that they were exposed to sexual and reproductive health information before their first formal video and four students identified that they found this information outside of their social support networks on television, YouTube, or a website. Considering the student responses, a comprehensive visual of current, desired, or not desired social support is listed in Table 7.

Table 7

<table>
<thead>
<tr>
<th>Types of Social Supports Students Have, Desire, or Do Not Desire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
</tr>
<tr>
<td>Immediate Family</td>
</tr>
<tr>
<td>Extended Family</td>
</tr>
<tr>
<td>Medical Professionals</td>
</tr>
<tr>
<td>Teachers</td>
</tr>
<tr>
<td>Friends</td>
</tr>
<tr>
<td>Cultural Groups</td>
</tr>
<tr>
<td>Spiritual Communities</td>
</tr>
<tr>
<td>Communities</td>
</tr>
</tbody>
</table>
Having a well-rounded picture of the world that these students are having their lived experiences in is necessary to best understand the commonalities between them. In the next section, the anticipated themes as well as themes that emerged during analysis will be detailed and applied to the context at large.

**Interpretive Analysis of Themes**

Narratives and stories have many parts. Bruner argues that one of these conditions is that stories often develop as a result of an event, real or fictional, deviating from cultural or behavioral norms thus developing either an exceptional or an ordinary result which develops the plot (1990). This aligns well with Transformative Learning Theory’s focus on significant life events like a divorce or a humiliating event as a motivator for comprehension and recall. Using narratives to understand how student lived experiences contribute to their sensemaking, interpretations of events, personal identities, and creations of communities can help to prevent narratives like the band-aid removal story from being the only content someone remembers from their sexual education course. The following section prioritizes the students’ own words in an effort to illuminate their wants and needs in order to create more positive narratives surrounding sexual education in the Mid-South and the United States. The five primary themes include awkward family discussions, strong preference for maternal involvement, safe spaces in friend groups, a desire for representation, and uncertainty and insecurity and are listed with definitions and exemplars in Table 8.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Definition</th>
<th>Example (Quote)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awkward Family Discussions</td>
<td>Students noted an uncomfortable feeling when talking about sexual and reproductive health with their families.</td>
<td>She said it's comfortable to ask her, but I am not comfortable asking her.</td>
</tr>
<tr>
<td>Preference for Maternal Involvement</td>
<td>Each student acknowledged their mothers were actively making discussions happen and would go to them if they needed something.</td>
<td>I don’t think she would lie to me I think she’s just honest and I trust her the most.</td>
</tr>
<tr>
<td>Safe Spaces in Friend Groups</td>
<td>Whether students regularly or infrequently spoke about these topics with their friends, their friends are a big part of their social support network.</td>
<td>I want to be with all my friends mostly just to make it more comfortable.</td>
</tr>
<tr>
<td>Desire for Representation</td>
<td>Students identified a need for more information not just for themselves but for their peers, even if it didn’t apply to them.</td>
<td>I did not feel represented in either the video or the instructor. There wasn’t a lot of inclusion with a lot of different groups. It did the bare minimum and somehow still spread the wrong message. It feels like they were targeting one demographic.</td>
</tr>
<tr>
<td>Uncertainty and Insecurity</td>
<td>Students shared a consistent fear of the unknown specifically related to this topic and were not embarrassed to say they did not know or had not been taught the necessary information yet.</td>
<td>I think it comes back to like most of us just don't have the right information. Proper information. So I think it was more of just off the bat, just in our heads being like, Okay, we should probably talk about this, but we don't really know how to . . . So we're just gonna say these words and they get the message across or, Okay, we understand, but also not really 'cause of us really know anything . . . We understand the idea of it.</td>
</tr>
</tbody>
</table>
Awkward Family Discussions

Students acknowledged a universal awkwardness felt when discussing these topics with their immediate family members. Although they trusted the credibility of information shared by their parents or siblings they also noted a hesitance to go to this support system first. For example, one student did not enjoy the delivery of the information as his mom tries to be serious but his step-dad just makes jokes which he found annoying. Instead, one student searches for information using, “Private tab web search on phone 'cause I'm curious, but I don't want my mom to look at it and be like, why were you searching up this?” When asked why they would turn to family with questions over other sources of information, one student said,

… I just kind of trust my family 'cause I know them. Yeah, also, I don't know if I would actually go to my family for that. I'm being honest, it's not really embarrassing talk on the topic, it kind of, I don't know, I feel like they would suspect something of me. I don't know, they trust me, but also they're like, don't go do that, and they don't trust me when I say I'm not going to. Which is fair, I guess they were teenagers too… I wanna ask my mom. She said it's comfortable to ask her, but I am not comfortable asking her . . . Yeah, 'cause it's always like, What if it turns out to be nothing? So I don't wanna just worry her for no reason.

Another student added that their mother liked to spring conversations about these topics on him in places like Target or the dinner table which he felt added to the awkwardness. He qualified this feeling by saying,

Sometimes she would talk about HIV, condoms. Since I’m 14 since I got older we’d have more conversations. She’s not pointing the finger at me but she was just trying to make
sure I knew this information so I could make my own choices….she’s not telling me like no sex before marriage.

Three students stated that there was not a way to improve conversations with their family members while two students did not wish to speak to family members more often on these topics.

Avoiding important conversations due to discomfort during the discussion will only continue to force students toward different, less credible sources of sexual and reproductive health information which does nothing to decrease adolescent rates of STIs or pregnancy. The awkwardness felt by the students as well as their families in these discussions can be explained by the religious and political influences in this region. With strong roots in religious values such as sexual purity and lawmakers citing those values as reasons why students should not be exposed to sexual education information, it is understandable that conversations would not be commonplace. I anticipate the students’ unfamiliarity with the topics because they have not been allowed to discuss sex education information previously is one of the primary causes of their embarrassment. Although these feelings may go away with the natural increase in maturity that typically comes with aging, waiting for that growth may mean students are already sexually active and experiencing a negative health outcome before they become comfortable talking about sexual and reproductive health. Diving deeper into what specifically is uncomfortable about discussions of sexual and reproductive health may unlock families, medical providers, and even communities as important resources that students previously did not think they desired.

Additionally, several students mentioned a fear of repercussions from parental figures who do not want them to be sexually active which may also increase the uncomfortable feelings students have when discussing these topics with their families. Notably, students did not discuss
conversation content as a source of embarrassment as often as they identified how the information was communicated, for example, at the dinner table, in a car, at Target Supercenter. If simply shifting the location of these conversations would help ease student anxieties and minimize students being forced to turn to Googling in private browsers to answer the questions they have despite minimal skills in determining source credibility, that is an immediate and manageable solution.

The students who did not want to speak with their parents at all also represent an opportunity for additional study. It would be naive to think that every family is functional and positive, particularly considering the historical interactions of queer adolescents and their families. The common narratives of being kicked out of their house if they revealed their queerness to their families or were found out by their families have kept many adolescents in the closet. These students would not be able to include their families in their educational experiences, if they are present at all. This is where other resources such as medical providers or teachers can step in as sources of additional support and it will be important to determine how the potential in these social support networks can be harnessed.

As a researcher, I place significant value on the concept of reciprocity. It is important to me that the students who took the time to share their lived experiences with me, also benefit from the research directly, above and beyond the participation gift card. In line with these values, I developed a conversation guide for how to bring up topics of sexual and reproductive health with their social support networks as well as an STI fact sheet about the STIs we discussed in the interviews. Anecdotally, these materials were very well received by participants, though most took photos instead of the hardcopy. Future research will be necessary to determine if this conversation guide is effective, and if so, if it can be expanded to include an activity for added
comprehension and recall. Additional opportunities to use this guide are present in the next theme.

Finally, I would be remiss to not highlight sexual abuse as a possible source of awkwardness in discussing topics of sexual and reproductive health. Even parents with the best intentions can influence their children to enact behaviors that do not serve them. Through a desire to protect children from information that is too mature for their age, parents often use terminology like “private parts” when discussing genitalia and instill values that encourage secrecy about their bodies. This can backfire as it makes it difficult for students to identify or discuss sexual abuse. Additionally, it is possible that the awkwardness felt about discussing sexual education topics is also derived from how these parents have framed sexual and reproductive health topics when their children were young in an attempt to prevent grooming or actual abuse from occurring. While present research focused on the lived experiences of adolescents, it may be beneficial to assess how sexual education information can be taught throughout development.

Preference for Maternal Involvement

Repeatedly, students identified their mom as the best source of information despite the potential discomfort associated with conversations about sensitive topics. One student, who frequently used examples of sexual education discussions with his mother, shared, “my mom knowing me, she explained it in the only way… 'cause she knows me as my mom, so she will explain in a way that she knew that I can understand it.” Another student echoed that he had a lifelong bond with his mother and, “I don’t think she would lie to me I think she’s just honest and I trust her the most.” Ultimately, directness and privacy seemed to be the tools to an effective sexual and reproductive health conversation as supported by a student who said, “My
mom has always been an advocate for, if you have a question come to me. 'Cause I will have an answer, [if] I don't, we will search it up to together and learn.” Another student added,

Sometimes when I wanna talk about sex and stuff I would rather have somebody else bring it up . . . I’m not gonna say hey . . . so I just wait for it to happen. So I feel like if that happened more often, it would be better for me ‘cause I don’t like to have conversations and this one is brought up already.

Four students believed that their mother is the person responsible for making sure they knew about STD/Is while others added church groups, educators, Google, and the government.

The method of using active conversations to create a space of comfortability and trust for sexual and reproductive health conversations supports Fasula & Miller’s research regarding the positive influence maternal tone and responsiveness has on adolescents remaining abstinent and increasing the age at first intercourse experience (2006). These findings are not shocking considering the gender roles in this region. While women everywhere are tasked with more childcare responsibilities and “second shift” labor, the Mid-South aligns more strongly with traditional or religious values such as these than a large metropolitan city like Los Angeles or New York would. This finding is echoed by Gould and Mazzeo’s study on adolescent information sources (1982). They found that across the age categories surveyed, females were 14 times more likely to seek information from a mother over a father compared to males of the same age category (1982).

In order to employ this previously less visible resource, mothers especially, but parents in general, must be directly involved in their children’s sexual education courses. Each student verified that their parents may have had to sign a paper allowing them to be exposed to the puberty videos; however, they could not recall any other parental involvement such as checking
assignments, critiquing a presentation for practice, or clarifying and processing information learned during the experience. This is a missed opportunity for sexual education developers and instructors.

In future research, it is imperative that parental, especially maternal voices, are involved. This could occur in the content of the course, but may be more effective in the design of materials for parents who have a child entering a sex education course. This course preview or crash course in sex education for parents would align with present research and not only help parents to be more actively involved in their child’s education, but also can help to correct any misinformation their learned in their own family life courses as adolescents. Students from the present study identified conflicting information from school vs. home as a source of confusion and frustration. Ultimately, limiting or eliminating any discrepancies between what they learned in school, and what they are being taught at home would give students the opportunity to focus more on the messages being echoed by the social influences in their lives. More research must occur to determine if parents want to be more involved or would be willing to attend a course preview event at all.

**Safe Spaces in Friend Groups**

Communities including spiritual or cultural, medical providers, or educators were mentioned infrequently; however, ranked underneath the preference for a mother or mother figure, students overwhelmingly trusted their friends as credible sources of sexual and reproductive health information. While one student admitted their friend group tries to trick or fool each other which could include when they discuss sexual and reproductive health topics, the majority seek advice from their peers. One student commented on the dynamic saying,
My friend group is really open about every topic we talk about, we could be in the lunchroom having the most normal, boring day, and I think it was right before school ended, it was Thursday, and it wasn't even about sexual or reproductive health, but we're in a conversation of what if women just walked around shirtless like men? . . . You know, let's dive deep into that…We just bring up conversations that we're all comfortable having and we're like, why is this the way it is? We’re looking out for each other, I trust my friends.

Another student confirmed that they talk about it, “all the time.” These discussions seemed to be so commonplace that students had difficulty recalling specific examples during the study. When asked where sexual and reproductive health or sexual education conversations should happen, one student mentioned, “I don’t know why a playground came to mind. Like with your friends talking about it late at night. It’s just no kids are going to be there late at night, more privacy.” This was supported when students were asked if there was anything that would improve conversations with their friend groups on this topic and five participants said no. The only extension that was shared mentioned that time is the only thing that could improve friend discussions of sexual and reproductive health topics. This refers to the fact that the student still felt like they were too young to be sexually active and their friend group would grow as they all mature before shifting to sexual education topics more frequently.

The students saw their peer groups as their teammates; everyone was in the trenches together. Thinking about their future sex education course, one student said, “I want to be with all my friends mostly just to make it more comfortable.” While this bond is necessary and important for their social and intellectual development, it is also concerning as students identified little knowledge of sexual and reproductive health topics which makes these interactions a case
of all students, no teachers. If a student is afraid to go to their parents about an interest in sexual activity and instead turn to their friends, they may leave the conversation with bad information. For example, that peeing after sex will prevent pregnancy, or using two condoms makes sex safer, or you cannot get an STI from oral sex so you do not have to use condoms or dental dams. These rumors, myths, and misinformation are dangerous in health settings specifically because of the finality of some of the consequences of health attitudes, beliefs, values, and behaviors. Students appear to be satisfied with the communications they have with their friends about these topics; however, that does not mean there is not an opportunity to better understand these relationships and help students to share more credible information.

When asked who is in charge of designing sexual education materials and who should be in charge of designing sexual education materials, I was honored to have several students mention me before their families or the government. What I found to be more interesting, is that no student suggested that themselves or their peers be involved in creating the materials they will be asked to use in a formal sexual education course. Whether the omission of student perspectives was an oversight, consistent with current educational material design, or a lack of interest in more labor, this is another area to be explored. Peer educators have been shown to be highly effective when attempting to influence adolescent behavior in sexual health contexts (Kopo, Lejone, Tschumi, Glass, Kao, Brown…& Amstutz, 2023, Hui, Krishnamurthy, Kumar, Siddegowda, & Patel, 2020). By utilizing these gatekeepers, researchers can tap into this already established social support network to help disseminate trustworthy, medically accurate, credible sexual education information. At the collegiate level, many clubs related to sexual and reproductive health already exist including Planned Parenthood support chapters, sexual assault awareness organizations, and queer alliance associations. This is another opportunity to increase
sexual education information inside and outside of the classroom as there may be less legal restriction on club activity making it a solution that could be implemented relatively quickly.

**Desire for Representation**

In both the lived experiences of these students and their future desires for an ideal sexual education course, students wanted to feel safe, not judged, and represented in the materials and in discussions in general. Considering the students’ primary exposure to sexual education materials in the puberty video of fourth or fifth grade, students recognized that separating the genders was unnecessary and thought that all genders should watch all videos. One student volunteered,

> We should all get the same information 'cause that's important, pretty much. As a male, I don't wanna constantly be learning about the male reproductive system, and I probably naturally already know a lot about it, so I'd also wanna learn about the female reproductive system, I guess . . .

They added that this information may be important later in life if they were trying to conceive or not conceive a child. Another thought the video tried so hard to be general that it was too vague and ended up not representing anyone. The student said,

> I did not feel represented in either the video or the instructor. There wasn’t a lot of inclusion with a lot of different groups. It did the bare minimum and somehow still spread the wrong message. It feels like they were targeting one demographic.

Even something as simple as the age of the actors in the video made students feel less represented. A student said,

> For the video that was being shown, the kids in the video that were supposedly talking about their experiences, they were much older than we were at the time, and of course they were . . . Of course going through different things that we were and by just the video
you could tell from that video, it had been filmed a while ago . . . Yeah, and so, of course different experience would happen now, and I mean as a non-binary person, I . . .

Looking back on it now, I do feel a little awkward just my younger self sitting in that room being like, This . . . This is really weird though, one, I'm being secluded like this from these videos, but I didn't feel separated from the videos really, I could still relate to some things.

One student shared the importance of representation particularly in family conversations. They shared their non-binary gender previously and noted their mother’s openness but highlighted an opportunity for improvement in inclusive language like saying, “someone” instead of, “when you marry a man or a woman.” They said,

I guess just like whenever my mom would speak about it . . . Oh yes, when you marry a man or when you marry a woman, I'd be like, yeah, whenever you marry someone or you like . . . Or whenever you're dating someone, just have that space open, and then also her thoughts being more open to like there are females with male genitalia and there are males with male genitalia. I know she's open to the idea of it is just in her language, she speaks, she isn't very like . . . She doesn't seem open to it . . .

All students felt that even though some information presented in their future class may not apply to them, it should still be included in the course. One student stated,

[If I didn’t have information that related to me] I would be confused I guess . . . But I guess I could use the information! When I have sex, I will only want it with [redacted for privacy], not shaming, but sure.

None of these students wanted any other student to feel uncomfortable, judged, or unrepresented despite having different lived experiences.
Each year we learn more about gender, biological sex, and sexuality. As we discover and create more labels and definitions, people are given the language they needed to classify pieces of their personal identities and the amount of Americans that now identify as a member of the queer community has increased. Because of this, the omission or condemnation of queer individuals in sexual education materials is doing a disservice to all students. Additionally, our awareness of the dangers of loneliness, isolation, judgement, shame, and bullying have also grown highlighting the struggle many queer adolescents face while navigating systems set up by leaders who would prefer they did not exist. These students consistently shared a desire for their experiences in general, but their sexual education experience specifically to be a safe space free of judgement. Bullying still occurs, but more and more students are being given tools to deescalate those situations and create a more inclusive classroom space. Adolescents are especially adaptable and understand concepts like pronoun use earlier than one might expect. This was one of the areas that gave me hope for the future. Instead of only caring about the information that served them, students wanted to learn about the lived experiences of their peers for reasons ranging from sheer curiosity to the information being useful in the future for a currently unknown reason, to just wanting everyone to have the information they need to be healthy. Students explicitly stated a desire for, “. . . facts, not opinions,” and understood that information which is too vague is not useful to anyone. Teaching peer educators as well as parents during sexual education class previews or crash courses may help to remove some of the stigmatization surrounding the queer community which would allow the inclusion of queer health materials in public school sex education courses. Unfortunately, these conversations have the ability to improve the lived experiences of individual students, but systemic change is a more lengthy and involved process.
Drawing conclusions and making recommendations in this section was the most difficult. Unfortunately for students and sexual education advocates, sexual education in the United States is severely limited by laws that are directly manipulated by religious, political, and historical influences. Many of my recommendations regarding representation would not be as well received as my suggestions that parents have more active discussions with their children about sexual and reproductive health. It is the systemic stigmatization and oppression of queer people that must be addressed in order to make improvements in this category. Though continued advocacy helps, tangible and immediate solutions are more difficult to enact.

One potential channel is the media. Most of the students recalled seeing sexual health information on television early in their lives. Social media has also changed how adolescents communicate and create communities, a fact that some sexual education content creators have already tapped into. There are innumerable TikTok accounts sharing sex education information on channels the students already use. Unfortunately, students did not seem to be interacting with this information meaning the TikTok algorithm is not presenting students with these lessons as they have not liked or interacted with enough similar content for it to appear on their pages. Research that centers increasing the audience of sexual education content on social media would be useful as a result.

**Uncertainty and Insecurity**

Before being asked about STD/I awareness, students communicated a very low level of confidence in their knowledge of STD/I information. Most of the students were conscious of this lack of exposure or knowledge, for example, one student stated, “…not many people talk to me about it I guess the most I know is seeing movies which is not really accurate.” Another participant added, “I think I need to be more heavily educated.”
All students were unable to share any information about the first STD/I, chlamydia, with five students saying variations of, “I know it’s an STD, that’s it.” This was the same for the second STD/I, gonorrhea. Students were able to share a little more stating, “It’s also an STD, and isn’t it kind of like a UTI in a way? That’s probably it,” and “Kind of sounds like diarrhea. I really hope that one doesn’t have to do with poop or anything.” The final STD/I, HIV, had the most awareness; however, students were still less than satisfied with their knowledge. The first student thought HIV could be transmitted sexually but also identified blood transfusions as a risk due to a recent blood donation with a family member. One student asked, “HIV is AIDS, right?”, while another said, “I know a few people that have it. It’s, I mean, gonorrhea and chlamydia target more of your reproductive system but HIV is more your immune system.” A third student said, 

I think what I’ve heard is it's more based on the male side of it, so since it's more easily aimed at a certain gender of that, you can better . . . They're like, Oh, since we know more about this, that means we can just talk about it better, or maybe there's [just] more people with it.

When asked to consider their own gender and sexuality and identify the biggest worry students have about their sexual and reproductive health, one student stated, “I don’t know yet because I don’t know the risks. I’m just kind of scared there is a risk.” Another student elaborated, 

I’m the most worried about catching something and I don’t know what it is. So being miseducated. I think that’s probably the most scariest thing. Because it depends on what you get but it doesn’t matter what you get you’re gonna be less scared if you know about it.
Participants of all genders expressed a worry about pregnancy scares, with the exception of one student who qualified her answer saying, “I have a lot of baby fever because babies are so cute. But the thought of being pregnant and at such a young age is scary.” Others added any STD/I, HIV, chlamydia, or HSV2 (herpes simplex virus 2) to the list of fears.

While students identified a significant lack of STD/I knowledge or awareness and shared specific fears related to their own gender and sexuality, when asked about how worried they were that they would contract an STD/I, one of the more cautious students said, “6/10? Because I am scared but I also think because I’m worried about it, I’ll take the necessary precautions so I don’t get any STIs.” Other students ranked themselves much less worried but added, “As of right now 2/10, but in a few years it might be higher,” eluding to the fact that none of the students were sexually active, and “Unless I knew how to get it, maybe then I would be worried.” The final student highlighted the theme of uncertainty when they said,

I don’t know, pretty worried cause I get pretty worried about my health sometimes cause that also doesn’t sound like a fun thing to happen and sounds like it could be dangerous too. I just get worried a lot and I don’t know much, I guess. So it’s kind of just like unknown.

Six students ranked oral sex, anal sex, and vaginal sex, in that order, from least (oral) to most (vaginal) risky but were unsure of the reasons they identified the different types of sex as risky. Two students noted that oral sex may have a risk of STD/Is due to the human mouth containing germs or being, “dirty.”

Although the students all identified some level of risk associated with oral, anal, or vaginal sexual acts, despite being unable to explicitly list what the risks were highlights the lack of knowledge as a potential source for the discrepancy between the theme of feelings of
uncertainty and insecurity. This may also be expanded to explain the shortage of student responses to the question about what measures they would take to protect themselves when they do choose to become sexually active. Four students seemed to haphazardly suggest condoms as a solution, and two shared the same tone when suggesting birth control. One student said, “Maybe make sure I actually know the person?” Otherwise the uncertainty was palpable.

In their attempts at uncertainty reduction, students shared what information they search for online as well as how they determine source credibility. Students said they would use Google, TikTok, Twitter, YouTube, and private tabs on web browsers to search topics including menstruation, puberty, condoms, birth control, and information on the mechanics of sex itself. No student volunteered if the topics of the mechanics of sex were located in educational videos or pornography and no follow up questions were asked in an effort to honor potential IRB protections of these vulnerable populations. Media literacy levels were low with only two participants detailing any search criteria including the author of the information or organization website. One student claimed that she trusted Twitter because, “there’s only 140 characters so you have to get to the point.” When asked if brevity and credibility were the same, the student doubled-down agreeing that the short nature of the channel of communication made it credible. Despite these uncertainty reduction attempts, it was clear students still desperately wanted even more, credible sexual and reproductive health information.

Uncertainty and uncertainty reduction were not anticipated themes in this research. Students are aware that they do not know much about sexually transmitted infections, and they are insecure about the information they do not know. However, students are not taking regular steps at uncertainty reduction. Though conversations with friends occur, as do internet searches, students rarely wanted to bring the topic up first, and instead seemingly hoping they will figure it
out as they go instead of seeking information or planning for different possibilities. Students shared that they would use private internet browsers to protect their privacy from other family members to avoid worrying them or being punished; but, with technologies available that restrict and monitor the internet use of minors, this is still a risk for students. This may account for why students mentioned few uncertainty reduction attempts.

Additionally, Witte’s Extended Parallel Process Model may offer insight into why the students have not taken action to reduce uncertainty or protect themselves from the perceived threat. According to Witte, when faced with a threat, people assess threat variables (perceived severity and perceived susceptibility) as well as efficacy variables (response efficacy and self-efficacy) before deciding how to proceed (1992). In the context of STIs, perceived susceptibility is the students’ beliefs that they will or will not contract an STI. Perceived severity would then determine the degree of importance to the students (1992). For example, when I asked if the risk of oral, vaginal, or anal sexual acts would change if we were talking about STIs in general, or a specific STI like HIV. In tandem, these variables make up the perceived threat; if a student believes the severity and the susceptibility to contract an STI are high, the threat will be perceived as high. After the level of the perceived threat is determined, students can shift to determining their response to the threat (1992). Self-efficacy would be the students’ beliefs that they are able, or unable, to effectively enact safe sex practices to prevent contracting an STI (1992). If students do not know about safe sex practices or do not believe they have access to barriers to STI transmission like internal or external condoms, they would have low self-efficacy in the face of this perceived threat.

As a result of these beliefs, three paths of control can occur. The low-threat path is taken when a student believes that it is unlikely that they will contract an STI and even if they did, it
would not make a significant impact on their lives so they choose not to engage with the threat or alter their behaviors to include practices that can limit STI transmission (1992). The high threat-low efficacy path is chosen when students attempt to control or reduce their fears about contracting an STI (1992). In this case, students believe they can or will contract an STI and STIs would have a significant impact on their health or lives. In addition to believing that STIs are a high perceived threat, students with this response also believe safe sex practices do not reduce the risk of STI transmission enough, or they do not have access to those measures. In this situation, students are scared of STIs but are not aware of or do not trust methods of reducing STI transmission and take steps to reduce their fear, often through denial, rather than reducing the perceived threat through action. Finally, the high-threat high efficacy path is the only path where we see active behavior change (1992). Students believe the threat of contracting an STI is real, are aware of the safe sex practices, believe they can enact those practices easily, and attempt to reduce the danger by using the recommended behavior modification.

Although it was not explicitly included in the present research, considering Witte’s fear control and danger control paths, students appear to fall into two of the three categories: low threat and high threat/low efficacy. As all the students self-identified abstaining from sexual activity due to reasons including an absence of opportunity, being too young, or being afraid of STIs or pregnancy, the lack of present sexual activity likely influenced the students’ beliefs about the severity of risk associated with STIs. If students are not engaging in the behaviors that will lead to STIs, they are not going to alter their behaviors in response to a determination that STIs are a low perceived threat. Additionally, the students who are not sexually active but are still worried about contracting an STI eventually were unaware of safe sex practices or preventative measures. When asked to identify barriers to safe sex practices when they do
engage in sexual activity, none of the students identified problems with access to prophylactics, birth control, or other measures. In this case their low-self efficacy is not related to accessing these resources, but instead related to their awareness of the diseases, preventative measures, and how to use them. This bottleneck in behavior change could easily be corrected if students were given medically accurate, age-appropriate sexual education courses in school. Future research using the extended parallel process model directly could help to ascertain students’ level of perceived threat related to STIs as well as their ability to follow suggested safe sex practices.

It is also important to note that according to anxiety-uncertainty management theory different cultures and different people have varying levels for feelings of anxiety and uncertainty (1995). For the student who labeled themselves as highly anxious, the level of anxiety and uncertainty is high. While students did not appear to engage in active uncertainty reduction related to STIs often, it is possible they engaged in passive strategies which are more observational (1995) such as watching how social support networks such as peers discuss STIs in order to determine the level of perceived threat or necessary behavior modifications. In conjunction with the extended parallel process model, future research to determine active versus passive uncertainty reduction strategies related to STI risk would benefit students and sexual education material creators alike.

Students reiterated that many of them elected to abstain from sexual activity because they knew that they were not ready, yet but did not elaborate on what would make them feel “ready.” This emphasis on it being too early may also play a role in students’ avoidance of the topic. While conservatives could count this personal restraint as a win for AOUM, not knowing when students will feel like they have enough information to confidently become sexually active is the potential danger. Similar to addressing awkwardness in family discussions, a timeline of when to
expose children to sexual education information as well as materials that represent age-appropriate, medically-accurate sexual education information would be useful. From assessing social support networks further, to exploring the impact of religious and political ideology exposure on student perspectives, understanding what else may prevent students from seeking sexual and reproductive health information is necessary.

The themes found in this study including awkward family discussions, preference for maternal involvement, and safe spaces in friend groups especially, highlight the significant influence of social support networks on sexual and reproductive health information seeking outside formal sexual education courses. Additionally, the significant uncertainty and insecurity experienced by these adolescents forefronts the importance of this project and research in the same vein. Because of legislation and policy that adults create and often vote on, our adolescents are scared and unsure. They cannot see themselves represented in the materials that are presented and are unprepared to engage in sexual activity, before or after marriage, so they look for help outside of school. This is an incredible missed opportunity to use existing channels to better inform and protect our students. In order to correct this, we have to include adolescent lived experiences and desires in sexual education material access and creation. In the following chapter, I will answer the three research questions of this project and identify areas of improvement as well as possible solutions.
Chapter 5: Discussion

Project Review

There are many academic areas of study including child development, psychology, or public health, that could have been used to complete this project. Unlike other disciplines, health communication foregrounds communication as the primary driver in student awareness and comprehension of sexual and reproductive health information as well as highlights the lived experiences of these students in ways that other disciplines cannot. Communication is a central experience which can then be used to navigate other influences (Craig, 1999) which allows for a more complete picture of how a student interprets and assigns meaning to a topic as well as the associated attitudes, beliefs, values, and behaviors that help to make up their worldview (Littlejohn & Foss, 2010; Orbe, 1998).

After examining the history of sexual education in the United States, the current state of sexual education, and relevant communication theory including the theoretical frameworks of phenomenological interviews, the relational health literacy model, health literacy tapestry, and transformative learning theory, I created the interview protocol keeping in mind the research questions as well as two other scholars’ dissertations which used the method of phenomenological interviews (Damico, 2004) (Kennedy-Reid, 2012). I then created the informed consent and assent documents. Although assent forms were not required by the IRB, it was important to me that the students gave consent in addition to their parents as one of the goals is to uplift the voices of these students. In February 2022, I spoke with the campus schools to determine if I would be able to utilize their population of 8th graders for recruitment.

I was met with excitement as this school was recently approved to add a high school and this class of 8th graders would be the first 9th grade class beginning in the fall. Administrators
seemed eager to not only have someone wanting to interact with the students for research purposes, a core value of this campus, but also to learn possible directions for these students specifically if a sexual education course needed to be added to the curriculum. I was almost immediately cautioned that my study may not be well received by parents, a limitation I had already considered. I was told that the parental landscape was strained as Critical Race Theory (CRT) was a controversial topic of discussion at the time, and several parents had threatened to sue the school if CRT was taught. I was left to infer that the parents would be equally unhappy with their adolescents being asked questions about sexual education topics. I am unsure if this impacted the way that the administrator chose to tread lightly when recruiting for this study; however, the recruitment and interview processes took the better part of six months as gaining interest and consent was difficult.

Ultimately, seven adolescent students’ parents responded to the administrator’s multiple requests to join the study. Due to the required anonymity of this vulnerable population, I am not aware of exactly how students were identified and recruited aside from being told that an email was sent to all of the parents of the 8th grade class. Anecdotally, two families who attend the school but did not participate in the study informed me that they did not receive such an email. This could be a clerical error or a miscommunication with the school administrator. All participants were 14 years old which is in line with the age at where students are about to be exposed to the Tennessee Lifetime Wellness Curriculum Standards, grades 9-12 or age 14 to 18 (State Profile Tennessee, 2019). This age category also matched the state’s highest age ranges for teen pregnancies and a portion of the largest group of new STD/I contractions in the state.

Each student participated in two interviews, one week apart, with the exception of one student who experienced an abrupt death in their family and was taken out of state for three
weeks. This timeline was designed to give the students time to reflect on the experiences they shared in the first interview and build on them during the second interview. This course of interview, time, reflection, interview, reflection also contributed to the hermeneutic circle (Littlejohn & Foss, 2010) and encouraged students to process the meanings they have created using transformative learning theory’s principle of reflection (Mezirow, 1997). The final interview was completed in August of 2022 and computer-generated transcriptions were ordered shortly after through the service Scribie before the transcriptions were cleaned and analyzed using interpretive phenomenological analysis.

The purpose of this study was to explore the topic of sex education from the perspective of the adolescents taking these courses as well as outside sources of STD/I information from stakeholders in order to establish a foundation for future research. The intent was not to use positivist or post-positivist frameworks to create a singular, generalizable view of sexual education in the United States (Braithwaite & Schrodt, 2014); instead, I focused on interpretive, phenomenological methods to gain a deep insight into the lived experiences of adolescents in the Mid-South paying special attention to Orbe’s goals of phenomenology to create a, “discursive space where those traditionally muted voices can be heard,” (1998). It was not possible for this study to produce universal results. Instead, this project aimed to answer the following questions in order to inspire future research that also forefronts muted voices and advocates for improvement in sexual and reproductive health information as well as sexual education as a whole.

RQ 1: How do adolescents in an urban mid-south city in the United States understand sexually transmitted diseases and infections (STD/Is) within the context of public-school sexual education courses;
RQ2: How do influences outside public school education inform adolescents’ understandings of STD/Is in the urban mid-south; and

RQ3: How can adolescent perspectives inform the redesign of materials, content, modality, and/or delivery of STD/I content in sexual education public school curricula in the urban mid-south?

By considering not only their lived experiences, but also their social support networks, and the historical, political, and religious contexts, I was able to use communication lenses to pinpoint areas of exploration to more effectively meet the wants and needs of our students. The following section serves to answer the posed research questions by revisiting the important contexts previously discussed in the literature review as well as offering the implications of the found themes, and identifying areas for future research.

Reflecting on Research Questions

While revisiting the methods section of this document, I rediscovered the justification I selected for speaking with students between the ages of 11 and 17 years old. In digging deeper into the Tennessee Health Education and Lifetime Wellness Standards for grade K – 12, I discovered several standards directly related to this project. It is important to keep these standards in mind when answering the following research questions through the lens of communication studies and interpretive phenomenological analysis. When I contacted the Tennessee Department of Education to ascertain if these standards are being adhered to or if there are situations where they would be allowed to ignore the standards, I was given one email address to contact. The representative has not replied to my initial email or follow-up request.
R1: How do adolescents in an urban mid-south city in the United States understand sexually transmitted diseases and infections (STD/Is) within the context of public-school sexual education courses.

Adolescents in an urban mid-south city in the U.S. do not understand sexually transmitted diseases and infections within the context of public-school sexual education courses because none of the participants have had a formal comprehensive or evidence based sexual education or family life education course. The closest formal educational experience to a sexual education class that students consistently recalled was one to two videos around fifth grade which contained information about puberty and anatomy. This is significant as it is in not in line with the current Tennessee Health Education Standards which state that students have experienced instruction on sexually transmitted infections (STIs) including HIV/AIDS, beginning in grade 3 (about 8 years old) with additional topics being added in grade six (about 12 years old) (State Profile Tennessee, 2019). In fact, Tennessee Health Education and Lifetime Wellness Standards for 8th grade, which these students just completed at the time of these interviews, state that students should be able to:

1. 8.HGD.11 Research strategies to develop and maintain reproductive and sexual health (including HIV, HPV, and common STIs),
2. 8.HGD.12 Compare and contrast behaviors, including abstinence, to determine potential risk of STI/HIV transmission, and
3. 8.HGD.14 Describe ways people can protect themselves against serious blood borne communicable diseases.

I explicitly asked students to rank the level of risk associated with oral, anal, and vaginal sexual acts. After they completed the task, they were asked if changing to a specific STI, rather than
thinking about STIs in general, would alter their ratings. This compare and contrast activity proved difficult and was more of a guessing game for the students than a recall exercise. If the students were being taught in line with the aforementioned standards, students would be able to compare and contrast behaviors, including abstinence, to determine potential risk of STI transmission, but they were unable to do so. In addition to these requirements for 8th graders, 6th and 7th graders, as differentiated with the standard code beginning with a 6 or a 7, should be able to,

1. 6.HGD.12 Define human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS).
2. 6.HGD.13 Distinguish between safe and risky behavior as related to disease prevention.
3. 7.HGD.12 Identify modes (age appropriate) of HIV transmission, as well as ways to prevent transmission.
4. 7.HGD.13 Describe situations that could lead to pressure for sexual activity and to the risk of contracting HIV and other STIs.

This brings into question what the purpose of these standards are as students had little to no awareness of HIV and no recollection of being taught about HIV in the 6th, 7th, or 8th grades. Compounding this confusion, these standards also directly conflict with the Tennessee School Health Laws which prevent teachers from presenting materials that promote “any gateway sexual activity,” or, “sexual activity among unmarried students,” and requires that the family life curriculum, “emphatically promote only sexual risk avoidance through abstinence, regardless of a student’s current or prior sexual experience,” ("Tennessee School Health Laws," 2018). These conflicting instructions can be used to explain why students have not received this information.
If teachers are not allowed to discuss topics that would be necessary to meet these standards, under the penalty of a potential personal fine as mentioned in the introduction, how do they effectively meet these academic standards? In short, they do not.

The educational and lived experiences of the seven participants of this study also in conflict with these standards as none of the students were able to recall HIV information with any level of detail and did not mention being taught this information in middle school. The ambiguity and confusion surrounding if these standards are supposed to be taught and how to achieve this goal is another area of future research. Are administrators failing to enforce or these standards or are teachers unsure of how to instruct these lessons? Does the context of Tennessee being a primarily conservative state with increasingly restrictive legislation controlling what information can be taught in public schools play a role? The context of the laws of this region will be discussed in RQ2. As Leslie Kantor from SIECUS’ claimed, there is no left-wing sex education, only right-wing and mainstream sex education (Jensen, 2010) so it is impossible to divorce the political values of the area from the sex education curricula and policies. Finally, if presented with the standards, how would students react? Would it stimulate a memory or would they be frustrated that they are not receiving necessary sexual and reproductive health information in school? These questions should be answered in future research that continues to forefront the lived experiences of adolescents in the area.

When asked about the formal sexual and reproductive health information students did receive, they confirmed that the puberty videos were both difficult to recall and not a positive experience, for conflicting reasons. On one side, students said that the videos seemed to contain not enough information, likely due to the restrictions on sexual education to be “age appropriate.” Echoing that their families and friends had already made efforts to conduct the,
“puberty talk,” students felt the video was redundant and did not learn anything new or relevant from the experience so they let their attention wander. This is interesting because research shows that for other subjects, like reading, repetition can be highly effective as a teaching technique (Munoz, Pattemore, & Avello, 2022). In the case of sexual and reproductive health information, students felt that they were already aware of basic anatomy from their social support networks so they wanted a more holistic picture of what to expect from their bodies, when and how to seek help if something unexpected happens, and a preview of lessons that would be introduced after puberty, which would include STD/I information.

On the other side, students felt like the videos contained too much irrelevant information that was not useful to them at the time and thus not retained for later use. One student mentioned that the actors in the video were significantly older than they were at the time as the actor had already completed puberty and it made the student feel like puberty wasn’t something that would happen any time soon. This is another reason why sexual education must be age-appropriate and age-appropriate must be explicitly defined. If students are taught that they need to be in a monogamous relationship within the context of marriage before they can engage in sexual activity (Santelli et al., 2017) it makes them tune out important sexual and reproductive health information because they see monogamy and sexual activity as too far into the future to make it presently relevant.

This can be reinforced by comparing other school subjects. For other subjects, what is “age-appropriate” is more easily determined. Most instructors would agree that average students in middle school would not be ready to read a college-level biology text. It is also easier to recognize that a student would likely not skip algebra 1 to instead begin in an advanced calculus course. But how can the same determinations be applied to topics of sexual and reproductive
health in formal sexual education courses? If the puberty video discussed condoms as a tool for reducing STI risk but students were not aware of what the STI symptoms or modes of transmission were first, information about condoms would not be presently relevant. If a student was not yet sexually active and did not have current plans to begin sexual activity, they would not find information on how to protect themselves during sexual activity presently relevant.

These progressions seem like common sense, in actuality, sex educators have an arsenal of tools for making these determinations. However, layers of educational restrictions and mandates made by lawmakers and politicians exclude their expertise from the conversation. In states like Tennessee, this means increasingly conservative values being adopted despite a more moderate view of sexual education being held by the average American.

In March 2022, Grinell College conducted a national poll which assessed adult desires for topics to be taught in schools or not. These responses were categorized by demographics like age and education, but also by political party. A likert scale was used and participants ranked topics from essential, important/not essential, not important, should not teach, and no response. Results are in Table 9.

Table 9

<table>
<thead>
<tr>
<th>Rank</th>
<th>Republican (380)</th>
<th>Democrat (304)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential</td>
<td>31%</td>
<td>55%</td>
</tr>
<tr>
<td>Important/Not Essential</td>
<td>37%</td>
<td>40%</td>
</tr>
<tr>
<td>Not Important</td>
<td>13%</td>
<td>2%</td>
</tr>
<tr>
<td>Should Not Teach</td>
<td>16%</td>
<td>1%</td>
</tr>
<tr>
<td>No Response</td>
<td>3%</td>
<td>1%</td>
</tr>
</tbody>
</table>

*Note: Independent voters were also tallied at a lower rate (251).*

While the polarization and division of our country’s political parties is a common topic of news in 2022, in this survey, 31% of republicans (117.8 people) and 55% of democrats (167.2 people) believe that sexual education is an essential component to be taught in public schools.
Additionally, 16% of republicans (60.8 people) and 1% of democrats (3.04 people) did not believe sex education should be taught at all. These numbers are not as polarized as anecdotal conversations and media representations seem to make it appear. The numbers could be due to the small sample size or how participants were recruited. However, if an average of 68% of republicans and 95% of democrats believe that sexual education is either essential or important/not essential, why are Tennessee sex education laws so severe?

In Tennessee, information is being restricted further and further. In 2021, Tennessee banned critical race theory (CRT) from public schools (Allison, 2021), a decision which directly impacted this study as administrators are now worried about any topic deemed controversial being presented in school. In 2022, House Bill 2557 prevented any organization, such as Planned Parenthood or Choices, a local sexual and reproductive health organization, who refers, endorses, or performs abortions from teaching family life (abstinence only) curriculum in schools (Tennessee State Profile, 2023). This attack on abortion providers as sources of credible sexual and reproductive health information, outside of the topic of abortion, is a direct result of Roe v. Wade being overturned in June 2022. During this assault on racial inclusivity and reproductive freedom and justice, Tennessee legislators have expanded this erasure of marginalized communities and pushed a record amount of bills targeting the queer community. From bills banning gender-affirming care for trans youth beginning in July 2023 (HB/SB 1), to requiring that trans youth participate in sporting events on teams that reflect their biological sex at birth (HB 306/SB 1237), to a bill which defines gender or biological sex in ways that discriminate against trans and non-binary folks which would prevent access to necessary resources and protections (HB 239), to restrictions on drag entertainers classifying them as adult entertainers that cannot perform in front of anyone under the age of 18 (HB 9, SB 3), thinly veiled
frameworks to keep the queer community marginalized are being established and fortified. Sexual education restrictions are also being strengthened by HB 727 and SB 1143 which requires written consent from parents to participate in any health lesson, as well as prevents LGBTQIA+ information from being included (Fields, 2023). The students in this study were aware of current events and brought them up of their own volition as examples during their interviews. Despite their active awareness of the limitations of their education, students also knew they did not have the ability to change these circumstances within the context of a formal sexual education course. This is why the inclusion of their lived experiences in the design of formal sexual education courses is so important.

Students continued to advocate for more inclusive information. For example, they desired an expanded view of gender during the puberty/anatomy videos. Students did not appreciate that the video viewing experience was separated into a gender binary with boys watching the “boy video” and girls watching the “girl video.” But it was not just queer students who wanted to see more than just the video of their own biological sex or gender. Students who do not identify as LGBTQIA+ also wanted to see what would be happening to their classmates in order to better empathize with their struggles and come together as a community as they grow. This would also allow students to act as liaisons, an organization communication role that connects several people from different networks (Farace et al., 1977) by using this information to share knowledge in formal sex education courses as unofficial (or official) peer educators.

This example of maintaining the gender binary during this process is just one of the ways that the queer community is erased from formal sexual education materials. As we learn more about the biology of sex, gender, and sexuality, pioneered by researchers such as Anne Fausto-Sterling in the early 1990s, it is necessary to expand past the gender binary. From non-binary
folks, to gender-fluid people, to dozens of different types of intersex adolescents and adults, we are becoming more aware of the need to include categories beyond “girl” and “boy” in order to teach all students, not just the assumed majority. Without the inclusion of this information, students who exist outside the gender binary cannot see themselves in the materials presented which means they are unprepared to engage in sexual activity safely and protect themselves from STD/Is or adolescent pregnancy. This is why bills like HB 727 and SB 1143 are so dangerous.

Additionally, both the inclusion of too much or too little information and the lack of representation of the videos speak to how necessary it is to tailor information to the population consuming the information. This is no different for STD/I or sexual education information as supported by scholars in both health literacy and mass communication who have declared that health information needs to be tailored to the target audience (Baker, 2006; Cairo, 2012). Rather than setting our students up to enact safe, risk averse health behaviors, this means that choosing or being forced to use generalized STD/I information actually limits opportunities for students to become aware of STD/Is and contributes to students being unaware of STD/Is within the context of formal sexual education courses, if they are offered these courses at all.

Ultimately students do not have an awareness of STIs within the context of public-school education because their public-school education actively and overtly restricts this information from being included. Unfortunately, it is the students themselves, future adults and community members, who will pay the price for this mistake in the form of negative and even terminal health outcomes.

R2: How do influences outside public school education inform adolescents’ understandings of STD/Is in the urban mid-south?
Using the modified relational health literacy categories as well as the health literacy tapestry, outside of formal sexual education, students could have received STD/I information from families, friends, medical providers, cultural groups, spiritual communities, laws, healthcare systems, and the media. Social support networks including family and friends are the primary source of sexual and reproductive health information, specifically STD/I information, for these adolescents outside the public-school educational system. Laws were not a significant source of information for the students likely due to the numerous and confusing restrictions in place for sex education.

Similarly, medical providers and healthcare systems, while likely the most knowledgeable, play little to no role in these adolescents’ sex education experiences. Research shows that for chronically ill adolescents, a lack of adolescent and family preparation for the transition from pediatric to adult care, as well as failure to conduct a formal termination of pediatric care, creates obstacles to successful transition of care (Reiss, Gibson, & Walker, 2005). This could be one of the reasons why participants in this study either did not have a medical provider or did not desire to discuss sexual and reproductive health with their provider. Anecdotally, this was echoed on a recent episode of the popular daytime talk show, The View. Sunny Hostin and the other hosts were discussing parenting, specifically, “the sex talk” typically had by parents and children. She told the other hosts that despite the fact that her husband is an orthopedic surgeon, her children would rather come to her about topics of sexual and reproductive health (de la O, 2023).

Although previous research concluded that talking to adolescents about topics of sexual and reproductive health does not lower the age at first sexual activity (Flores & Barroso, 2017), and instead, if the conversation was considered positive by the adolescent, often delays sexual
activity (Karofsky et al., 2001), advocates, religious leaders, and policymakers throughout the country aim to restrict access to sexual education information under the false pretense that they are protecting children from topics they are not ready to encounter as well as from adults who are “grooming” children. A spokeswoman for Florida Governor DeSantis claimed that opposition to the “don’t say gay” bill which prevents educators in early grades from introducing sexual orientation and gender identity means the person in opposition is, “probably a groomer or at least you don’t denounce the grooming of 4-8-year-old children,” (Natanson & Balingit, 2022). Education Professor at Virginia Commonwealth University studying sexual abuse, Dr. Charol Shakeshaft, counters that sexual education is necessary and adds that, “Children who have learned that teachers or school personnel aren’t supposed to do certain things … are much more likely to go to an adult to report it,” (Natanson & Balingit, 2022). Assistant Professor studying evangelical politics and the white-nationalist movement at Vanderbilt University in Tennessee, Dr. Sophie Bjork-James, identified this message framing of sex education in the context of sexual predation of children is an intentional and effective tactic as anyone who opposes it, like Governor DeSantis’ representative claims, is “inherently evil,” (Natanson & Balingit, 2022). These are just a few of the active barriers to sexual and reproductive health information within formal settings that force students to look elsewhere for necessary information. As discussed in research question one, there are standards in place that require SDT/I information be presented as early as 3rd grade; however, an obvious disconnect has occurred between these standards being instituted, enforced, or tested if none of the present study’s participants have completed these lessons. This is why the social support networks of these students are so important to how they assign meaning to the world around them, specifically related to STD/Is.
Through American social norms and traditional gender roles, mothers, if present, are constantly forced to step in and fill any role that is left vacant in their children’s lives. Snacks have to be made for the team soccer practice, dinner has to be cooked, and laundry has to be done. This is the concept of second and third-shift labor occurring for working mothers, especially middle-class mothers in heterosexual relationships (Dworkin, & Wachs, 2004). Acting as a source of sexual education and STD/I information also falls into maternal responsibility. This may be as a result of mothers primarily taking on the kinkeeper role. A kinkeeper is a family member who is responsible for information dissemination and relationship maintenance, a role commonly filled by older women who connect strong and weak-tie family relationships (Leach & Braithwaite, 1996). All participants could recall concrete examples of a time when their mother helped them to understand a topic of sexual or reproductive health, and most volunteered an example about STD/I information without prompting. Despite the potential for mothers or other family members relaying outdated or inaccurate STD/I information, this is still a positive result. Past research determined that using a maternal tone of comfort and responsiveness sexual education conversations at home makes teens less likely to become sexually active, more likely to remain abstinent, and delayed sexual debuts (Fasula & Miller, 2006; Guzmán et al., 2003). The theme of awkward family conversations also correlates well with these claims. Students isolated bad humor, inappropriate setting, and tone as reasons why these conversations may feel awkward.

Family communication is highly patterned and can be used to explain these feelings of awkwardness. Depending on if a family is conversation-oriented or conformity-oriented, feelings of discomfort in sexual and reproductive health conversations may decrease or increase. If a family is high conversation, they enjoy talking and would feel more comfortable, while low
conversation families would feel less comfortable being forced to have these types of conversations (Koerner & Fitzpatrick, 2002). Additionally, high-conformity families may result in adolescents who adhere to those in authority like parents or older siblings, while low-conformity families are more open to challenges of authority and elevate individuality (Koerner & Fitzpatrick, 2022). In families like Owen’s or Lindsey’s who had high conversation and low conformity, conversations occurred frequently and with little feelings of awkwardness, though some were still present. Families like Bee’s appear to have low conversation and low conformity where conversations do not occur often, but if they do, do not leave family members feeling as awkward. Sam’s family seems to be low conversation, high conformity, resulting in extreme anxiety surrounding sexual and reproductive health conversations. Finally, Bill’s family appears to be high conversation, high conformity, where questions were allowed to be asked but conversations occurred during inappropriate times or felt less open to direction from the adolescent. Analyzing family communication styles during sexual and reproductive health conversations is an area of future research that is necessary to more effectively use this already established channel of information. Another highly established channel of sexual and reproductive health information outside of formal sexual education courses was friend groups.

Students felt comfortable seeking insight from their peers and, though less often than with family members, could recall a specific instance of a STD/I discussion that occurred in their friend group. This could be one of the passive uncertainty reduction strategies students used. This preference for peers is also supported by Gould and Mazzeo’s information-seeking research which found that as adolescents age, males and females increasingly rely on their peers for information (1982). Notably, they also found that females tend to rely on their peers earlier and more often than their male peers (1982.) The reliance on peers during the information-seeking
process is a great opportunity for behavior modification. Consider recent legislation in Florida, modeled after similar legislation in Tennessee, to ban information ranging from gender identities and sexuality to menstruation (Singh, 2023). If parents have not previously prepared their adolescents who will experience menstruation and it will not be taught in schools, where will students get this necessary information about what will happen to their bodies? For anyone who has experienced a first menstrual cycle, the occurrence can be terrifying even if you were prepared effectively. These students shared that the internet and their friends, both sources with significantly varied levels of credibility, fill that information gap. However, if medically accurate, age-appropriate sexual education courses were introduced in Tennessee, peers would step in outside of the formal educational setting as another, already established channel of more credible sexual and reproductive health information. Armed with vetted, credible information, peers could then act as a safety net to combat the inaccurate, misinformation and disinformation being disseminated by Departments of Education, rooted in the political and religious influences of the surrounding areas. These findings echo the necessity of microsystems, or, “proximal contexts in which the young person participates in directly, such as the family, the peer group, and the school,” and highlight that while students are experiencing the associated “substantial independent influences on health-related attitudes and behavior of adolescents,” (Perry, Kelder, & Komro, p. 74, 1993), the influences of the school on student’s sexual and reproductive health are an untapped opportunity for positive health behavior change.

Another area for future research is the information seeking process of sexual and reproductive health topics through media channels. In the same Tennessee educational standards related to HIV information, students were also tasked with being able to:
1. 8.HGD.17 Evaluate the influence of media on personal values, attitudes, and beliefs.

None of the students could remember the first time they encountered sexual or reproductive health information outside of their families, but several students suggested it was “probably” on television or a pop-up advertisement on their computers. Especially due to the anonymity and privacy associated with information seeking using computer-generated search engines like Google, students felt like they could locate STD/I information here first, before turning to their families or friends as to not worry them or be accused of anything other than curiosity. This identity management strategy was reiterated by three of the students in this study. Not only did we discuss how the students determined if a source was credible but also the concept of representation and how students believe sex education or STD/Is were represented in the media. Despite the standard listed above claiming that students should be able to evaluate the influence of media on personal values, attitudes, and beliefs, none of the students could answer the question without a large amount of explanations on my part first. This is concerning since one participant selected all of Twitter as a credible source of STD/I information above and beyond it being credible due to its forced brevity which is not a method for determining source credibility. Students were also unable to give common signs of a credible source such as author credentials, who owns the website, or date of publication (Osborn, Osborn, & Osborn, 2011) without prompting.

Students are turning to the media, oftentimes before their families, but cannot or do not think critically about the sources of information to ensure they are receiving factual or trustworthy communication. When asked what a community of true and trustworthy sexual and reproductive health information or STD/I information would look like, students were unsure.
This means that during the information-seeking process, students would click the first source that pops up and take what is written as gospel which is especially dangerous as organizations such as True Love Waits and Silver Ring Thing actively oppose premarital sex and have no legal or moral obligation to present credible STD/I information (Gardner, 2011; Moslener, 2015). Organizations like this also have the ability pay for sponsorships that pull their search results to the top of the page. Considering paid advertisements, organizations with, for example, an evangelical objective can use fear appeals such as, “you can get HIV from holding hands,” to influence adolescents instead of sharing scientifically factual methods of contraction. This circles back to why tailoring credible STD/I information is so important. Without that safety net in place, outside the formal sexual education course microsystems that act as sources of STD/I information such as parents and peer groups could disseminate misinformation and/or disinformation and students or their peers and families will think it is credible.

Without access to current comprehensive or evidence based formal sexual education classes, students in this area are forced to use their social support networks to supplement the lack of sexual and reproductive health information presented to them in school. This makes the influence of the role of stakeholders outside formal sexual education even more significant as they do not experience the same restrictions of federally or state funding sexual education lessons.

R3: How can adolescent perspectives inform the redesign of materials, content, modality, and/or delivery of STD/I content in sexual education public school curricula in the urban mid-south?

It was difficult for students to answer questions about their desires for a future sexual education course because they had never been asked to share their perspectives about this topic
before. I related as I remember being an adolescent and not having much say in the content of my lessons. As a result during this project I had to shift my approach and start asking them to analyze the list I previously gave them compiled from the Guttmacher Institute’s list of evidence-based sexual education topics. This helped to act as a starting point to get their minds turning. The students were instructed not to go home and do any research, just come with the information they had been given by formal sexual education courses and their stakeholders. As the students did not have formal sexual education and had difficult, inconsistent, or non-existant sexual education experiences with their stakeholders, this likely explains why the students were unable to answer without prompting.

One of the biggest takeaways is that students wanted all the information and none of the pressure. They wanted the ability to learn about the human body in a judgement free, stress free, fear-appeal free environment. We know from previous research that fear appeals are ineffective especially related to sexual health information (Denford, Abraham, Campbell, & Busse, 2017) and it gave me feelings of hope to see that adolescents confirmed this without any prior knowledge. The students’ requests for an open dialog without judgement or jumping to conclusions may have been reinforced by experiences of shame and stigmatization given the religious, political, and historical contexts of the area. For example, a student may have already experienced bullying or shaming from teachers and peers for asking a question about sexual and reproductive health in church or may have heard a queer family member discuss a loss of rights or a personal attack and see sexuality information as private. This concept manifested in course requests through a desire for anonymity during information seeking, flexible grading, opportunities to excuse themselves without penalty, and peer support.
Students wanted anonymity during information seeking to protect from feelings similar to those that occur during awkward family discussions but in front of their peers. Students attempted to name the feelings including judgement, embarrassment, anxiety, and shame. Ironically, students all shared feelings of uncertainty and insecurity but were more concerned with preventing the aforementioned feelings to reach out to any of their stakeholders or participate in other information seeking uncertainty reduction measures aside from private internet web browsing. Brené Brown, one of the most popularized and mainstream shame researchers, developed shame resilience theory and has countless projects detailing the negative psychological and physiological consequences of shame. Brown defines shame as, “the intensely painful feeling or experience of believing we are flawed and therefore unworthy of connection and belonging” (Brown, 2006). Adolescents are particularly concerned with achieving a sense of belonging with their peers (Tomova, Andrews, & Blakemore, 2021) and will alter their behaviors in an effort to achieve this goal. Many of these suggestions were manifestations of identity management or identity concealment techniques, especially for queer students who are not ready to openly discuss their sexuality. Queer adolescents in particular want to have agency in when they disclose their queerness and will commonly hide their sexuality, identity concealment, while navigating social interactions (Schmitz & Tyler, 2017). For this reason, opportunities to ask questions in an individual manner such as emailing the teacher directly were preferred over having to raise your hand during class. Students also unanimously wanted an anonymous questions box so that the teacher could read through the questions ahead of time, and answer them publicly at the beginning or end of class. This would also give students who were too shy or felt stigmatization or shame, such as those in marginalized communities including the queer community, the potential to have their question duplicated by another student. One of the
students suggested using a written form to communicate questions when discussing sexual and reproductive health with their medical providers as well.

Again, unanimously the students were not interested in a sexual education course that centered around strict or harsh grading policies. As we found in research question one, students have not been given the opportunity to have a formal comprehensive or evidence-based sexual education course so their genuine curiosity would be their motivation in a sex education course, not a grade. Their ideal sex education class would likely be an elective, though that would likely defeat the purpose of requiring a sex education course. There is something to be said for not giving the students absolutely everything they wanted in a sex education course. In order to motivate them to interact with the material, they may have to be graded on some level. As a solution, students echoed that adding a pass/fail option instead of a multi-level points system would let them learn and ask important questions without worrying it would somehow impact their grades. This would also help eliminate the issue of missing points if a student removed themselves from a lesson due to being uncomfortable or triggered by course content. This was an important suggestion for a few students who noted high anxieties and would also safeguard against triggering any students who may have experienced horrific situations such as rape or sexual abuse.

Finally, and most importantly, students called for peer support. This is not shocking after the results of RQ2, but reinforces how strong adolescent peer groups are. One student hoped there would be opportunities to be silly with their friends such as trying to see how big they could blow up a condom during their prophylactics unit. It is important to remember that while adolescents are young adults, they are also still children and play can be highly effective as an effective, memorable teaching method (Turner, & Martinek, 1999) which is true for adults as
well (Lewis, Saydak, Mierzwa, & Robinson, 1989). Another student suggested that group projects would allow students to find out that they had similar STD/I risk aversion levels or misinformation their siblings gave them. We should utilize peers as a way to make this potentially awkward or uncomfortable topic less embarrassing or scary for students.

Ultimately, students just wanted to be assured that their peers shared their uncertainty and insecurity about STD/I information and that it was okay to be curious about their sexual and reproductive health. It is this curiosity and openness to learning that should be cultivated, not repressed. Students have a desire for sexual and reproductive health information and they will engage in information seeking behaviors with less than credible sources if we do not step in as educators and lawmakers to provide them with better information.

Limitations

During the research process, several limitations to the study’s validity arose including speaking to students at only one middle school location, the number of participants, researcher method experience, and common issues with self-reported data. First, only one middle school was used to recruit participants. This school was selected primarily because it is a laboratory school which frequently calls for college students and faculty on campus to utilize their students as research pools. A 2019 university-wide email announced,

“Research efforts across [Redacted] Schools are being streamlined and enhanced. Researchers are invited to submit proposals for [Redacted] Schools related to research projects for the upcoming academic year. Each of the [Redacted] Schools website contains a research tab where researchers may propose projects that will be supported and vetted by the [Redacted] Schools Research Consortium…”
At my initial meeting, the campus administrator shared how excited they were for this project due to the fact that the elementary school had added a middle school and a high school was beginning the following year. Additionally, the administrators were unsure and unclear about what requirements, if any, they would have to abide by in reference to sexual education courses. This is particularly concerning as the Tennessee Health Education and Lifetime Wellness Standards suggest that these students specifically should have already received three years of repeat information about STD/Is in general and HIV/AIDS specifically, under their watch.

Using only one school is a limitation because while this school is under the supervision of the public school, county educational board, the same as all the other public schools in the area, there are geographic and administrative barriers to attend the school. While generalizable data was not the goal of this study, it is still important to note that various demographics or student lived experiences may not have been reflected in the responses due to only one sit being utilized. Similarly, only seven participants were interviewed, for a total of fourteen interviews. The goal of this research was to gain a depth of information on students’ lived experiences rather than a breadth of generalizable information on the state of sexual education in the area as a whole. While seven participants would not be considered valid, replicable, or achieve saturation, in this qualitative, phenomenological study, there was more than enough shared by the students to achieve these standards.

Researcher inexperience with this method was also a potential limitation. Especially during the first interview, a barrier to open communication was perceived by the researcher. While this could be as a result of a personal issue the student was experiencing, it also could have been the researcher’s lack of recent interview experiences, phenomenological interview
methodology, or conducting interviews with adolescents. Thankfully, almost immediately the researcher employed their years of experience with interviewing and also working with children. The discomfort or limitation could be attributed to nerves due to the significance of the project. Relying on self-disclosure as a method will always involve the limitation of dishonesty. Although the students were promised privacy and anonymity, there is always a chance that they do not trust the researcher or the research project. It is possible that students omitted or fabricated information during their interviews as an identity management technique to protect themselves from possible embarrassment or punishments if privacy was not enforced properly. This is a valid fear as privacy seemed to be challenged during one interview. Within the last five minutes of the interview, a mother entered the classroom. This was against protocol and an oversight as the parent also worked at the school. I cannot fault the mother as the student was late for a medical appointment and she was advocating for the health and well-being of her child, something I wish more parents would do. Additionally, the student had no reaction to being interrupted, despite sensitive topics being discussed. This reinforces the level of trust and honesty that was found during this study regarding the mother/child relationship that may also prove useful in future research. In addition to the aforementioned limitations, the researcher also faced challenges conducting the study related to the Institutional Review Board, middle school administrators, the political and educational contexts of the state of Tennessee, and student availability over summer break.

**Researcher Challenges**

I anticipated speaking about the sensitive topic of sexual and reproductive health with a population considered to be vulnerable, adolescents, in the Mid-South, an area historically against comprehensive sex education would trigger the Institutional Review Board to request
additional safeguards. While the IRB process was lengthy, this was due to a clerical error as my assigned reviewer did not review the project. This was rectified quickly and I was approved to begin interviews within six weeks of submission. Thankfully my awareness of these contexts helped when one of the first and consistent limitations of performing this research occurred. As I was not allowed to have any prior contact with the students, recruitment became a task for the designated school administrator. I was warned that several parents threatened to sue the school months before relating to the instruction of critical race theory. I was also warned that this, coupled with students having full summer schedules with camps and vacations would elongate my timeline, and it did. I sat down with the administrator in February 2022 and did not finish both interviews for every student until August 2022.

Being unable to contact the students personally as well as relying on outside assistance to recruit when recruitment was not a primary goal for the administrator was often frustrating and a significant limitation of the study design. Despite this, I understand that few people get opportunities such as this to co-create knowledge with minors in a school setting and it may be necessary again in the future to defer to the system the school has in place, in order to gain access to the participants. I am grateful that there were only two instances where I was scheduled for an interview, arrived, and the participant did not.

A related challenge was not only the schedules of the students, but also my own schedule. Six of the seven second interviews occurred within a week of the first interview, but one was conducted over a month later due to an emergency cancellation. It was also necessary to restrict the timeline of this project as this is a dissertation; while it would have been wonderful to gain access to more than one school, it was simply not possible given the finite nature of graduate school.
Implications

While the stakes are high for unplanned pregnancies or lifelong diseases and infections like HIV, there are high risks barriers to care, health literacy issues, and governmental intervention problems in most health concerns discussed in health communication. Considering the Tennessee Lifetime Wellness Standards, strong reliance on social support networks for sexual and reproductive health information, and access to private media sources, why were these seven students only barely able to identify gonorrhea, chlamydia, and HIV as STD/Is, and give little to no other context with the exception of one student who attributed the knowledge that HIV can be transmitted through blood to a recent trip to a blood donation center? The answer is likely a tornado of miscommunication and the influence of religious ideologies and political leaders, as previewed in the literature review.

First, students are unaware of STD/I information because students are not being given formal sexual education courses within the context of public school education. Despite the required standards and unacceptable rates of STD/Is and adolescent pregnancy in Shelby County, family life education courses are not required unless, according to state code § 49-6-1302, the county has a birth rate higher than 19.5 per 1000 15 to 17-year-old females ("Tennesee School Health Laws," 2018) which would not go into effect until students reach high school age. Additionally, when present, family life instruction curricula is restricted by Tennessee code § 49-6-1304 which can professionally and financially penalize teachers who do not adhere to the goals stated in the previous paragraph. Anecdotally, if I were a teacher worried about losing my job or being fined, I would be hesitant to teach anything related to sexual or reproductive health as well. These harsh restrictions on sexual education courses have been in development since the 1960s when conservative and religious leaders placed a spotlight on shifting sexual values to scare
citizens into aligning with their political agendas (Irvine, 2004; Jensen, 2010). The extended history of attacks on sex education like the revolt against SIECUS in the Anaheim Union High School District in 1969 and Regan’s Adolescent Family Life Act (Moslener, 2015) show the endurance and strength of the political and religious grasp on sexual education in our country.

At the same time as maintaining their hold on current and historical sex education restrictions, conservatives and evangelicals continue to chip away at what can be taught in schools. We can see examples of this in the past year with Critical Race Theory or the “Don’t Say Gay” bill, but new bans are requested daily such as the 2023 Florida push to ban discussions of menstruation before 6th grade citing, “woke ideology” as the reasoning (Tran, 2023) as well as anecdotally in my interactions with the middle school administrator. Ironically, community stakeholders like sports teams or church groups also have little to no role in adolescent exposure and comprehension of STD/Is according to these participants. While the states of Tennessee and Florida as well as GOP lawmakers have called for the responsibility of creating health literate adolescents to shift to the parents, no support is being created or funded to educate parents who may not be aware of updated or accurate sexual education information and students already feel comfortable talking to especially their mothers before even their friends or medical providers or lawmakers. But if the qualified stakeholders in an adolescent’s life are not being utilized for sexual and reproductive health information, it renders conservatives’ need to advocate for this method of education moot.

Additionally, this assumes that all parents are capable and willing to take on that role. As we have learned, one-size-fits-all rarely fits anyone. As a result, it is necessary to have a safety net in place to reach students with less-than-ideal home lives. Otherwise, students who are already struggling with social support are at a higher risk for the STD/Is and unplanned or
unwanted adolescent pregnancies which are still at concerning levels in this area. More efforts need to be made to educate our students in order to protect them from the negative sexual and reproductive health outcomes associated with a lack of sexual education information. This is difficult because there are barriers to these efforts set into effect by state and federal lawmakers which funnels the responsibility of teaching sexual and reproductive health back to the social support networks completing the cycle of miscommunication and restricted access to sex education. Everyone thinks that someone else is responsible for adolescents acquiring sexual and reproductive health information but it is the adolescents who pay the price or a failed public school sexual education and stakeholders who cannot or will not act as sources of information or believes someone else will.

Students also confirmed they were unsure of who should be responsible suggesting their families, teachers, and even myself, which was very flattering. What was especially interesting about this group of students is that they understood that they knew very little about sexual and reproductive health from their only experience in the public-school system. At the same time, they achieved risk-salience or risk-aversion and were aware that chlamydia, gonorrhea, and HIV exist and they should be afraid of them. The interesting piece is that the group participated in a limited level of uncertainty reduction practices in order to learn what they know that they do not know, or why they are afraid of catching an STD/I and instead focused on identity management to prevent judgment or stigmatization. Future research is necessary to better understand why this was their lived experience.

Thankfully, for these students specifically, they had not yet engaged in sexual activity so there was still time to give them the sexual and reproductive health information necessary to enact positive, risk-salient health behavior decisions. To their disservice, there are currently no
public or legal plans to offer a comprehensive sexual education course, or any sexual education course, aside from the family life education courses which again are only required by this school district when the adolescent pregnancy rates reach 19.5% out of 1,000 15 to 17-year-olds ("Tennessee School Health Laws," 2018) or include their voices in the conversation at all. This is something I warned the students about after asking them to share their fears and hopes for their future sexual education course. It was important to me that the students knew that their voices were heard by me, and possibly the administrators, even if their suggestions and perspectives did not come to fruition in the sexual education course they are allowed or asked to take.

During the dissertation defense, I was given excellent advice by my committee members regarding additional connections that could be made between the body of knowledge and this project. Although supported by the current literature, future research is necessary to determine if these themes can be replicated in varying contexts. For example, students from this particular school did not regularly engage or engage at all with the many diverse religious groups that exist in the bible belt. As we cannot divorce the lived experiences of these adolescents from the religious contexts of this area, the sexual and reproductive health attitudes, beliefs, and values from actively religious students may result in other themes and experiences not had by non-religious students. It is important to note that religious communities, evangelicals especially, are not against sexual activity, they are against sexual activity outside of marriage, either before marriage or in the form of adultery. Dr. Andre Johnson noted that local churches have held sexual education courses and Dr. Sarah Potter added that evangelical sex manuals for married couples exist and shared an example from the 1970s. These reminders can be used to develop future research that involves religious communities as stakeholders in adolescent sexual and reproductive health knowledge.
Another suggestion by Dr. Joy V. Goldsmith and Dr. Antonio de Velasco included the potential application of youth participatory action research (YPAR). YPAR, “involves young people constructing knowledge by identifying, researching, and addressing social problems through youth-adult partnerships,” (Anyon, Bender, Kennedy, & Dechants, p. 865). Used primarily in qualitative research, previous studies have used ethnography, grounded theory, phenomenology, randomized trials, quasi-experimental, pre and posttest, case study, cross-sectional, and longitudinal designs to gather data through survey, archives, observations, interviews, focus groups, and photo or video (Anyon, et. al., p. 873). Youth participatory action research is expanding quickly in qualitative, health education research and, like phenomenological interviews, also forefronts the lived experiences of adolescents through guidance from qualified adults to, “to actively intervene in order to change knowledge and practices to improve the lives of youth and their communities,” (Anyon, et. al., p. 865).

This aim on active community improvement is also a goal of the present study. While students were given two, $25 gift cards, they also received a conversation guide and STD/I quick facts flier at the end of the second interview. This information was designed by using credible sources and following information design principles gained during coursework to develop an age-appropriate, easy to understand document. Only one student elected to take the flier home, all students took a photograph on their cellphones to use later. It is important to remain objective and make active efforts to avoid influencing the participants; however, it also felt unethical to ask students to identify STD/I information, and allow them to continue to believe that information was true, if it was not. By being intentional about helping these participants directly as well as the community, this study echoed a core goal of YPAR.
YPAR also fits seamlessly with the use of transformative learning theory as well because YPAR requires students to have multiple interactions and revisit their attitudes, beliefs, and values surrounding their experiences during a process called communicative learning in transformative learning theory (Mezirow, 1997). The focus on making meaning together as a youth-adult partnership is also one of the foundational concepts in YPAR. Finally, small sample sizes like the seven students who participated in this are also valid in youth participatory action research. A 2018 Systematic Literature Review regarding YPAR contained 22 studies with 10 participants or less with an average of 135 participants per study. That number may be skewed by three outliers that included over 700 participants. Although the sample size is valid, future research directly using YPAR and involving more students from multiple schools could help to best identify and narrow the initial themes found in this study to better engage the community as a whole.

Considering that local agencies like Choices or Planned Parenthood are no longer allowed to teach sexual and reproductive health information in schools due to the conservative agendas being pushed through the state’s legislature presently, reproductive health and justice organizations are unable to do what they do best, inform and serve this community. It is as though every potential safety net for these students has been snipped or tangled and they are in a free fall into the unknown with many potential dangers. We are making few attempts to increase their health literacy and are frequently distracted by both important issues like gun safety and unimportant issues like restricting access to bathrooms based on biological sex and not gender presentation. These students are being taught in an interesting time in educational and political contexts especially. What it means to be an adolescent has changed but the resources available have not increased or evolved with them. On top of the limitations we are aware of including the
lack of a formal class, the failures of their stakeholders and communities, and the lasting historical contexts of the area, each student has their own personal issues and contexts that as researchers, we may never become aware of. While these themes and implications are a place to start, the focus needs to be on these students who have been put in an impossible situation by those who are supposed to protect them. More attention needs to be given to the needs and wants of these students and their lived experiences need to be seen as valid and important if we are ever to improve the way we teach sexual education and the students learn sexual education.

**Calls to Action**

These calls to action are not a cure-all for the challenges these students face in seeking, understanding, and applying sexual health information. There will never be cheat codes to use to help students become more sexual and reproductive health literate; however, these problems and suggestions identified by the students using their own lived experiences can serve as a starting point while attempting to influence the dumpster fire that is sexual and reproductive justice and sexual education in Tennessee. First, the lack of clarity and apparent contradictions between school health standards, state health education laws, and students’ lived experiences need to be addressed and corrected. Concrete, readily accessible information about what adolescents are being taught about sexual and reproductive health, by whom, and why are imperative. Transparency from school boards and law makers will help to better support the families carrying the heavy burden of social support for STD/I topics. Transparency will also illuminate which topics are legitimately inappropriate, and which are being used by religious and political leaders as a distraction from other, more important conversations. Separation of church and state is a value that originated in the Bill of Rights when our country was founded but has not been upheld, especially in this circumstance. While all Americans have the right to religious freedom,
only one religious perspective and agenda is being funded millions of federal dollars to be present in public schools, despite research proving the extensive shortcomings of abstinence only until marriage education.

Related to the themes of maternal trust and awkward family discussions, there is a need to train parents and their children on how to have conversations about sexual and reproductive health or even conversations in general. Since the Anaheim Union High School protest and school board challenges, parents have been calling for less governmental involvement and claiming that it is up to the parents to educate their children on these topics. Unfortunately, in Tennessee and other states, claiming that parents should be in charge of what their children are taught, and then restricting what other parents would like to be taught is the highest form of hypocrisy. Concurrently, while there are many popular culture books related to child development and raising children, there is not one perfect manual for your child and many parents are not as informed as they could be or would like to be. Teaching parents and children how to navigate these important but awkward conversations is vital to address the shortcomings of this stakeholder category. In the same vein, parents, especially mothers need to be directly involved in their child’s sexual education class whether it is in a public-school setting or through an outside organization. Participants vaguely remembered their parents being asked to sign a form allowing them to view the puberty video, but that was the extent of their involvement. Parents must play a much more active role in their children’s’ sexual education experience and future research needs to be conducted to determine effective methods for integrating parental participation. While students are comfortable going to their parents if they have a question, they also note the awkwardness and often wish the discussions occurred in a different way. Research
that tests the different styles of communication between parents, students, and educators would directly benefit the students as well as their social support networks.

Learning these communication techniques will also trickle down to more effective conversations between peers which are already occurring. Students who are particularly quick to comprehend and apply these techniques should also serve as informal and formal peer educators. The involvement of an adolescent’s friends will help to create a classroom culture of safety, free from judgment and stigma. If formal sexual education courses are not available, clubs or coalitions modeled after collegiate clubs like Friends of Planned Parenthood should be created to fill this need. It would be a missed opportunity to ignore a channel of information seeking and communication that has been supported by research for almost 50 years. The involvement of adolescent voices in these areas will also increase their stake in the information and increase engagement.

We have done a disservice to especially sexually queer and gender queer students. They are not aware of what risks they may encounter as they become sexually active or how to prevent or address them. All students regardless of race, gender, sexual orientation, biological sex need to be informed about all student sexual and reproductive experiences. This will not only raise awareness that people have different experiences but all experience similar uncertainties and insecurities, but also makes them more equipped to empathize and interact with people who are different from them as they age and begin to vote. Students want to know about what happens to the genders different from their own which is also a need filled by formal and informal peer educators. However, and arguably most importantly, marginalized students desperately need to see themselves in their course. This not a population that can just be ignored and made to navigate the terrors of the sexual health landscape on their own; they are vulnerable members of
our society who need our attention and support. Queer folks have some of the highest STD/I rates as well as suicide rates in the country, compounded geographically. Instead of actively attacking queer folks through formal legislation that tries to limit discussions of gender and sexuality, which will happen through informal channels and social support networks whether lawmakers like it or not, representations of all students should be added to the sexual education curricula. Compared to their peers, queer students are more than four times as likely to attempt suicide (Johns et al., 2019; Johns et al., 2020). This is unacceptable. We need to do better for these communities.

Adults with even a modicum of self-awareness or limit to their privilege can admit that growing up is hard. We are adding insult to injury by failing to support our students the way they desire to be supported. Students will never be able to eliminate feelings of uncertainty and insecurity; however, we can help them to cope using uncertainty reduction techniques, expose them to important information as well as credible and critical information seeking practices, and offer resources both in and out of the school system where they can turn if the feelings become overwhelming. We do not have to make our student continue to feel this. We have the power to help make them happier, healthier, more confident students.
CODA

In December of 2020 I met Taylor. Thinking I would be graduating soon and planned on leaving this horrific state, I was not interested in a serious relationship; however, I was desperate for human connection as I had been strictly quarantining for months. By February 2021 we were monogamous and basically living together, how cliché. Shortly after that, Taylor started to experience extreme bouts of nausea and stomach pains, sometimes vomiting so often they could not go to work. This forced me to confront my privilege because if I had experienced even the sniffles let alone a debilitating symptom like nausea, I would have called my primary care physician and scheduled an appointment immediately thanks to the Affordable Care Act and my low-cost health insurance. Taylor however, did not qualify but also did not have access to health insurance through their job at the time. In fact, they had not been covered by health insurance since they were on their parent’s insurance nearly a decade earlier. With my elevated health literacy, I took to the internet to find low-cost or free resources for uninsured Memphians. I was surprised, though I should not have been, to find that there was one viable option at the time, urgent care and primary care services provided by Church Health on a sliding scale based on income.

To foreshadow the conclusion of this experience, as I write this, Taylor is sitting on a milk crate behind the counter at work, miserable, trying not to vomit. I had already experienced the excessive wait times and religious judgements from Church Health during my search for a primary care physician, but this was the only option for Taylor. After only dating about eight months we moved in together officially and I became Taylor’s personal medical advocate and caregiver. We were told that primary care appointments were on a waiting list basis, but urgent care was open and only cost $40. During our first visit to Church Health, I was allowed to be
with Taylor in the exam room. Nauseated and seated in the hottest room in existence, next to the restrooms, we waited for over an hour, even contemplating leaving without being seen. When a resident finally came in, they explained their symptoms and I expanded on their answers. The attending physician who was supervising this student never entered the room. A battery of tests were ordered, all of which came back normal. During our second visit, I was not allowed to go back with them despite my protests, and told Taylor to record the doctor so I could listen back later. A different attending physician met with Taylor and expressed a significant lack of empathy. Similar to my blood clot experience, Taylor, who is non-binary, was consistently misgendered and told it was just anxiety and to reduce their stress and see a therapist. It was probably a good thing I was not present as that would have triggered an aggressive lecture about medical provider bias from my soapbox. In December, at our third visit to Church Health, I was exhausted from PhD, work, and caregiving responsibilities, and did not pull any punches.

The snarkiest intern alive called Taylor’s name out in the waiting room and we both walked up to her. She informed me that I was not allowed back, to which I replied I was Taylor’s caregiver, citing both the health communication definition of a caregiver and Church Health’s posted policy that states, “Patients and Caregiver ONLY in waiting rooms.” With an eye roll and no conversation, she guided us back. I attempted to lighten the mood by complimenting her nail polish while I handed her Taylor’s current medications. Crickets again. We were put into another exam room where a third attending physician listened to Taylor’s symptoms and finally ordered more extensive tests. It was no coincidence that the physician who finally listened was not a straight, white, male. Due to the holiday, these tests were not completed until January 2022 and they came back normal. For about six months, Taylor’s symptoms virtually disappeared. Ecstatic
at our return to some level of normalcy, we enjoyed the free time that had previously been spent at doctor’s offices. Unfortunately, Taylor’s symptoms increased in severity and frequency.

I felt so helpless that during a particularly terrible episode, I convinced Taylor to let me take them to the only emergency department in Memphis that accepts uninsured patients. This unicorn of a physician’s assistant listened, actively searched for causes, and identified possible sources of the symptoms. She informed us that they found something, likely unrelated in the scans that confirmed the scans from January, the scans we were told showed nothing. Taylor was given some medications, that did not work, and sent home where we later received a $4,000 medical bill that we still have not paid. Our second trip to the ER, had similar results. No one knew why Taylor was feeling so bad, and they weren’t willing to do more invasive tests due to the fact that there was nothing suspicious on any of the scans. More fluids, more nausea medications, another $4,000 bill.

At some point during this process Church Health, who had completely abandoned us after they put Taylor on the 4-month estimated waiting list for a primary care physician with them, they suggested a new organization that might help. Unfortunately, the hoops required to be seen were nearly impossible, such as requiring a letter from the manager at the last job Taylor had, and quit, confirming they were no longer employed. Exhausted, eventually we stopped returning their calls.

I never wanted to get married. I find the institution outdated, misogynistic, heteronormative, and expensive. I’m not the poofy dress, huge family, don’t even get to enjoy the food you paid for at the wedding type of bride. I even hate the word bride. But people fought hard to give queer people marriage equality, a right my high school best friend recently utilized. In venting to her and explaining why I was so against marriage, it occurred to me that I had never
followed the typical path, I always found my own way. So marriage did not have to be in line with what everyone else wanted, it could be for me, to protect my relationship and my partner. I jokingly mentioned to Taylor that it would be so much easier if we got married and they could just be on my insurance. The more I researched this, the less comical our tone became. We had been together for nearly two years, survived a global pandemic, accidentally adopted a dog, and moved in together. We were in love. Why should we not benefit from the business contract of marriage? On November 27, 2022 we got married in our living room, which my high school bestie and her wife decorated with twinkle lights and balloons. Our pets interrupted the four-minute-long ceremony and we fake signed the papers that apparently now do not require a signature.

I added Taylor to my insurance immediately; however, because it was too close to the beginning of a new year, it would not go into effect until January 2023. We selected a doctor and made the appointment for January 4th. During this waiting period, we visited my mother in Denver, CO for the winter holidays. Not even 8 hours after we landed Taylor experienced one of the worst episodes they have ever had. From our visits to the emergency departments, I knew that Taylor needed intravenous nausea medication and fluids; but, we did not have insurance yet. Even if we did, it was not the fancy kind that lets you see a provider out of state. What Denver does have that Memphis does not, is a more consumeristic, though equally problematic, capitalistic view of medicine. Meaning for the low, low price of $200, Taylor could go to an IV specialty clinic, walk-in, and receive immediate care. It worked within a few hours and they were feeling better, until they weren’t. Unable to pay $200 repeatedly, they toughed it out in bed, missing most of the plans we had made. We were grateful for two days where Taylor felt okay and we were able to visit Meow Wolf and the Garden of the Gods. This episode lasted longer
than any of the others and left us both feeling even more desperate and helpless, solidifying the decision to get married and add Taylor to my health insurance.

The primary care provider, Dr. Marshe Turner, was one of the only people who has really heard Taylor and me during this process. She spent over an hour getting patient history, there was a lot since Taylor had not been seen by a primary care physician in over a decade, and took her time understanding their struggles. We received an immediate referral to a gastrointestinal specialist and were told to wait for a call. The intake appointment was with a physician’s assistant and took all of five minutes. Taylor was told they would have one of two tests done, and if they vomited before the test, to call back and the second test was added. We were going to have them add the second test either way, but Taylor did have an episode. The anxiety leading up to potentially having an answer almost 2 years in the making was intense. After the test, the anesthesia kicked Taylor into another episode and the providers did nothing. It was an outpatient surgery center so I’m not sure what I expected but it was not to shove Taylor into my car without a second glance. The tests were essentially normal. To say I was devastated was an understatement. We are both so exhausted, I’m honestly shocked I was able to complete a full draft of my dissertation at all. The physician’s assistant followed up with us and just like the doctor, told Taylor to stay away from trigger foods, acid, caffeine, large meals, drink water, exercise, get more sleep, blah blah blah, be more healthy, this is your fault. It feels like once again we are back at square one.

I made a follow up appointment with the primary care physician who is my provider now too, because it’s hard to impress a skeptical, once burned, twice shy, health communication scholar, and goodness, she impressed me. Unfortunately, that appointment is not for another couple of weeks. Not only did we plan to ask for new medications, but also a second opinion.
from another GI provider. In the interim, being unable to do nothing and watch my partner suffer, I joined a Facebook support group for one of the diseases the doctor mentioned was more rare, but potentially could be the source of the nausea. I have lectured on the importance of strong and weak tie social support networks in chronic illness before, and even tried a group previously for one of Taylor’s possible conditions and did not enjoy it. Fortunately, this time, the Facebook group did something dozens of medical providers in Memphis couldn’t: diagnose Taylor.

I was absentmindedly scrolling through the posts after my approval to be admitted into the group. Taylor was having an episode and took a hot shower, a solution that sometimes helped. Every post was something Taylor had experienced or doctors had also said to us. I barged into the bathroom rapidly quoting these struggling strangers. I could not believe how spot on everyone’s symptoms and experiences were. This is unheard of as people often react differently to both the diseases and medications. This was one of the reasons I left the other group. I even asked a question and received confirmation from many people that Taylor and I were not alone. The minor relief I felt to have an answer was not palpable, but felt like progress. I know how difficult it is to force a doctor to take you seriously, even the good ones. So I will withhold my judgements for May 1st, when we follow up with our doctor. What does feel incredible, is being able to go into the appointment armed with information. I have new medications to try, the name of the disease, and typical courses of action. All thanks to a few strangers on the internet. It is my hope that very soon, Taylor will feel physical and emotional relief and we will not have to hesitate to live our lives because, “what if Taylor isn’t feeling good that day,” or my nagging fear, “what if what happened to me happens to Taylor and it really is life threatening but we can’t get care?”
Conclusion

Although religious leaders, conservative politicians, and opponents of comprehensive sexual education seem to believe that the goal of sex education courses are to corrupt our students, we actually all have the same goal: keep our students healthy, safe, and happy. The goal of sexual education courses is to arm our students with the information necessary to protect them from the potential dangers of sexual activity, primarily sexually transmitted infections and pregnancy, but also sexual assault and intimate partner violence. The information and resources upcoming generations have access to is only increasing, but at what cost? If we do not make active efforts to expose our students to sexual education information, this plethora of inaccurate information and even information overload will cause our students to determine their health behaviors based on opinions or myths instead of credible facts. In order to give our adolescents the best chance at a healthy and happy life, our society has to move past the shame and stigmatization of discussions of sexual and reproductive health. Through uplifting adolescent voices and empowering them to directly influence educational course like sexual education, we can solidify the concept of agency and personal advocacy which will only help to improve all aspects of their health moving forward.

I believe the final words of this dissertation should not be my own. These seven students were open, honest, welcoming, and vulnerable while sharing their lived experiences with me which gives me so much hope for their futures specifically and the world at large. When asked what advice they would give a younger friend or sibling who would be taking a sex education course, these are their stories.

“Try to have open, comfortable conversations about it with family. And even though it might be uncomfortable just do it I guess. I know that sounds harsh but like just try to get
it out of the way I guess, maybe. Since they probably don't wanna talk about it, they can just go ahead and try to talk about it and maybe learn about it and stuff instead of holding back for too long until . . . I don't know, they actually start getting sexually active and they don't know what they're doing. Maybe they could get an STI for not being careful but maybe they don't understand consent at all they can be put in jail.”

“For any information that anyone else gives you, always take it with a grain of salt, but don't stop taking in information, like never refuse information, but always understand that information may not be helpful and understand that might be scary, that any information you get might not be true. But understand, that's the way of life. That all again is truthful, and that's just how it goes. And I guess that keywords as saying that everyone deals with differently and everyone's body is different on how they react to it, so if something ever happens in your parent all says like, oh no, that should not be happening. Go to your doctor first because you're not gonna know more than anyone else, probably like it's completely wrong and you need help, or if it's like that's normal, it's just not on everyone, and it just also happened, everyone here understands.”

“Don't be scared, approach all information steadily, don't believe everything is true, but also, don't distrust everything, 'cause a lot of people just don't believe everything. And also don't feel intimidated [or] like a self-conscious and just kind of be like a kind of a resilient sponge absorbing certain information and squeezing out others.”

“I would say listen to the teacher, take in all the information, you may have your own beliefs, but you don't wanna be as our person who was that . . . I'm like, no, I don't
believe that. This is why I believe it's like that. I feel like you should be all ears, like you should be listening to be respectful, that's what it is. You'd be respectful of other people's beliefs and thoughts, even though you don't believe that you should still be respectful and nice, and don't be rude and not outgoing, but extra.”
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Appendix A

Interview 1 Protocol

INTERVIEW 1

a. Descriptive Demographics
   
i. Age: _________________________
   
ii. Gender: _________________________
   
iii. What kind of cell phone do you have? _________________________
   
iv. Race and ethnicity: _________________________
   
v. Education
      
1. Current School: _________________________
2. Current Grade: _________________________

b. Personal History
   
a. Who is in your family? (This can be blood relatives or declared family.)
   
b. What groups do you belong to? (Hobbies, extracurricular activities, sport, church etc.)

b. Sexual Education Experience
   
vi. Have you taken a class that includes learning about sex, sexuality, biology? What grade were you? Can you describe those classes to me?
   – If no skip to STI Knowledge.
   
vii. In what ways have any of your parents or guardians been involved in your sexual education experience in school? (ex. Did they have to sign a form to let you take the class? Were there homework assignments that
they had to help with? Did you practice a presentation in front of them etc.)?

viii. At any point in any of your courses do you remember talking about

(Guttmacher Institute Content Requirements)

1. Contraception (Y/N)

2. Abstinence (Y/N)

3. Importance of Sex ONLY Within Marriage (Y/N)

4. Sexual Orientation (Y/N)

5. Negative Outcomes of Teen Sex (Y/N)

6. HIV (Y/N)

   a. When provided must include:

   b. Condoms (Y/N)

   c. Abstinence (Y/N)

7. Gender Roles (Y/N)

8. Healthy Relationships (Y/N)

9. Sexual Decision Making and Self Discipline (Y/N)

10. Refusal Skills and Personal Boundaries (Y/N)

11. Consent (Y/N)

12. Dating and Sexual Violence Prevention (Y/N)

ix. Thinking about that information and all of your courses (Guttmacher Institute General Requirements for Sex and HIV Education):

1. Did you think the information was true and trustworthy? (Was Medically Accurate) (Y/N)
2. Do you think the information was at the right level for you and your age? If no, was it too much information or not enough information?
   a. Was Age Appropriate: (Y/N) Too Much Info or Not Enough Info

3. Did the instructor/information provide all possible choices or only one choice? (Was Culturally Appropriate and Unbiased) (Y/N)

4. Was there any mention of religion? (Did NOT Promote Religion) (Y/N)

x. What did you spend most of your time learning? (e.g. Anatomy, abstinence, family life, medically accurate information etc.)

xi. Did you have any experience with sexual or reproductive health education (what about other places? Sources?) before taking this class (like a class at a local organization or church)?

xii. How did your sexual education course make your feel?

xiii. Were you represented in your sexual education course? Did the information apply to you? Why/why not?

xiv. Do you think your sexual education course was effective? Why or why not?

xv. Who do you think is responsible for creating the sexual education materials you interacted with?
xvi. Share an example of a time where you used information from your sexual education course (correct or not) in your life outside of class.

d. STD/I Knowledge

xvii. How well do you know STD/I information?

xviii. What do you know about chlamydia? (What is it, how do you get it, can you treat it, how? Etc.).

1. Where did you learn this information?

xix. What do you know about gonorrhea? (What is it, how do you get it, can you treat it, how? Etc.).

1. Where did you learn this information?

xx. What do you know about HIV? (What is it, how do you get it, can you treat it, how? Etc.).

1. Where did you learn this information?

xxi. Thinking about your sexual and reproductive health, what are you the most worried about? (ex. What is the biggest risk in your eyes?) Why?

xxii. How worried are you that you will contract a STD/I?

xxiii. Think about your sexual orientation and gender. If you were to have unprotected sex without any methods of preventing STD/Is:

1. Describe how risky you think oral sex is.

2. Describe how risky you think anal sex is.

3. Describe how risky you think vaginal sex is.

xxiv. Does the type of STD/I (chlamydia, gonorrhea, HIV) change your responses?
e. Information Seeking and Health Literacy Co-Creation

xxv. Where do you first remember seeing sexual and reproductive health information?

xxvi. Who is responsible for making sure you know about STD/Is?

xxvii. Where do you get information about STD/Is now?

xxviii. What kind of STD/I information do you search for in those places?

1. Why do you use this way of getting information over others?

xxix. How important is true, trustworthy STD/I information to you?

xxx. How do you and your immediate family discuss sexual and reproductive health topics?

1. Give an example of a time that your family helped you to understand a sexual or reproductive health topic AND you used that information later.

   a. How could this information have been better communicated?

xxxi. How do you and your medical provider discuss sexual and reproductive health topics?

1. Give an example of a time that your medical provider helped you to understand a sexual or reproductive health topic AND you used that information later.

   a. How could this information have been better communicated?
xxxii. How do you and your friends discuss sexual and reproductive health topics?

1. Give an example of a time that your friends helped you to understand a sexual or reproductive health topic AND you used that information later.
   a. How could this information have been better communicated?

xxxiii. How do you and your cultural or spiritual communities discuss sexual and reproductive health topics?

1. Give an example of a time that your cultural or spiritual communities helped you to understand a sexual or reproductive health topic AND you used that information later.
   a. How could this information have been better communicated?

xxxiv. What would make it easier for you to communicate with your family about sexual and reproductive health?

1. Your friends?
2. Your medical provider?
3. Your community?
4. Your teachers?

xxxv. How does the media (TV, Movies, Podcasts, Social Media etc.) talk about sexual and reproductive health?
xxxvi. Are there any channels of STD/I information that you do NOT trust to be reliable or credible? Why?

1. How do you determine if a source is reliable or credible?

f. Sexual History (TCA 49-6-1304 Family life education shall...“Emphatically promote only sexual risk avoidance through abstinence, regardless of a student's current or prior sexual experience.”) Reiterate to participants that information will not be shared with parents.

xxxvii. Are you sexually active (sex includes oral, anal, and/or vaginal manipulation with another person using either physical anatomy or sex toys)?

1. How old were you when you first became consensually sexually active?

2. If not sexually active, what has influenced your decision to not have sex?

xxxviii. When sexually active with another person what kind of measures do you take to prevent STD/Is?

xxxix. Where did you learn about the measures you mentioned?

xl. Have you ever had a STD/I?

1. If yes, what was your response? (Ex. Who did you discuss this with? What did you say?)

xli. When you have consensual sex or when you do eventually have consensual sex, what would make it easier for you to practice safer sex to
prevent STD/Is? (e.g. access to STD/I screenings, privacy to keep prophylactics etc.)

1. Do you face any challenges to these safe sex practices? (ex. Parents not interested in discussing sexual topics, not sure which information is true/trustworthy etc.)
Appendix B

Interview 2 Protocol

A. Transformative Experiences

i. What questions did/do you have going in to your sexual education course?
   1. If a course was taken - How did the information presented answer these questions?
      a. If a course was taken - what would you alter about the lessons?

ii. How did your sexual education experience make you feel? OR How do you want your sexual education experience to feel?
   1. What would you change about this experience?

iii. Share a particularly memorable lesson or experience from your sexual education class.
   1. What would you change about this experience?

iv. What changes have you made (if any) in your STD/I practices since taking a sexual education course?

B. Future Directions

i. What would you like to change about your STD/I knowledge or behaviors moving forward?

ii. What advice would you give to a younger sibling or friend about sexual education courses?

iii. Do you feel like your voice was heard in your:
   1. Sexual education course?
2. Family discussions?
3. Medical provider discussions?
4. Friend group discussions?
5. Community discussions?

iv. Who should be in charge of what is taught in sexual education courses?
v. Describe your ideal sexual education course.

1. Are there certain things you think students should learn in sexual education courses?
2. Are there certain things you think students should not learn in sexual education courses?

vi. Is it important to talk about sexual and reproductive health topics outside of a school sexual education class? Why or why not?

1. Where should these conversations happen?

vii. What would a community of true and trustworthy sexual health information look like?

viii. Is there anything else researchers should know?
**STI Fast Facts**

**Chlamydia & Gonorrhea**
Chlamydia and gonorrhea are both very common infections spread through sexual contact with fluids (semen, pre-cum, and vaginal fluids). While they often have no symptoms, you can experience itching, burning during urination, abnormal discharge, general swelling or pain in the genitals, anus, or throat.

Treatment: Cured with antibiotics

Prevention (if abstinence is not an option):
- Condoms and/or dental dams during vaginal, oral, & anal sex.
- Testing between all partners and/or regular testing with current partner.

**HIV/AIDS**
HIV (Human Immunodeficiency Virus) is an STI that, if left untreated, can develop into AIDS (Acquired Immune Deficiency Syndrome). HIV is spread through semen, vaginal fluids, anal mucus, blood, and breast milk. Early symptoms mimic flu symptoms.

Treatment: When using a combination of medications, the virus can become "undetectable" which means it is unlikely to be transmitted to anyone else, but the virus will stay in your system permanently.

Prevention (if abstinence is not an option):
- Condoms & Dental Dams
- Regular STI Testing
- PrEP (a daily medicine approved for people assigned male at birth)
- Utilize clean needles for prescribed drug use.
- If you have open cuts/sores, avoid contact with fluids.

**More Information**
When googling, pay attention to who wrote it and what their qualifications are. Excellent sources (used in this flyer) include:
- CDC.gov (search STD Fact Sheet)
- Planned Parenthood (click learn)
- kidshealth.org (click for teens & sexual health)
Let's Talk!

Having conversations about sexual and reproductive health topics can feel understandably scary or embarrassing. You may be worried about being judged or having the other person jump to conclusions. While you can’t control how someone responds, preparing can make you feel more confident and help the conversation go smoothly. The good news is, the more often you try, the less likely you are to feel this way! The following questions can act as a guide to help you navigate these important talks.

STEP 1: RESEARCH & PREPARE
- What do you hope to achieve with this conversation (goals)?
- What message are you trying to communicate and why?
- What notes can you take to help guide the conversation?

STEP 2: CONSENT & SCHEDULING
- What is your emotional state and what is the emotional state of the person you want to talk to?
  - Are you both open to talking?
    - If they are not open, can you wait until they are or try another trusted adult?
- ASK: I would like to discuss *topic* with you because I value your guidance/expertise. When is a good time to talk?
- Make sure to select a location where you feel comfortable (if possible) if not, bring or wear things that make you feel more at ease.

STEP 3: BOUNDARY SETTING
- Are there any topics you do not want to discuss? What about the person you are talking to?
- What is the expectation of privacy?

STEP 4: FOLLOW UP
- ASK: How do you feel after our conversation?
- Set a time to talk again. The more regular your conversations are, the more comfortable you both will feel and the less worry or judgment will be felt!

OTHER RESOURCES:
- How to Talk to Your Doctor About Sex (sexualbeing.org)
- Let’s Talk About Safe Sex: How to Talk About STIs/STDs with a New Partner (everlywell.com)
- How To Talk To Your Friends About Sex (thegoodtrade.com)
- Talking to Your Parents About Sexual Health (teenhealthsource.com)