“There’s No One Right Way to Experience Sexuality” Analyzing Youth Experiences of Sexuality Education through their Perspectives on Sexual Wellbeing in Rural U.S.

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Abstract

This thesis explores the experiences of sexuality education of four gender-diverse youth living in Maine by seeking to understand the impact and role of sexuality education within their sexual wellbeing. Specifically, the research uncovers how these young people conceptualize and practice sexual wellbeing, and the various barriers and supports which shape their experiences of it. The research is guided by theoretical frameworks of reproductive justice, queer theory, disability justice, and Native Feminist theory. Findings indicate that to these young people, sexual wellbeing is understood as a relationship of care with themselves based on their own perceptions of their sexuality and all it encompasses. To them, sexual wellbeing is contingent on their access to resources, interpersonal relationships, education, and safe spaces, and the barriers and supports they encountered were obstacles and enabling factors related to these categories. Based on the research findings, several recommendations are provided as paths forward in tearing down barriers and bolstering supports in allowing young gender-diverse people in Maine to practice sexual wellbeing.

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Chapter 1: Introduction

My sex education experience took place when I was sixteen, in my public high school in central Maine. It was a unit that was a few weeks long, wherein my classmates and I received pamphlets on the gender characteristics of boys (aggressive), and girls (shopping). My noticeably uncomfortable gym teacher showed videos of condoms being rolled onto dildos and told anybody who would like a live presentation to "meet him after class." I've since realized this is ahead of the curve. Since I started working on this project, many of my friends, family, and even acquaintances will readily tell me about their sex education experience. Some will not have even had a course or any formal sexuality education. In the case of a friend of mine, his sexuality education began and ended when his instructor clapped him on the shoulder, said, "You boys seem like you know what you're doing" and dismissed him and a friend for the day.

Sexuality education is defined by the UNFPA and WHO Regional Office for Europe, as learning throughout a young person's sexual development from early childhood to adulthood which provides them with knowledge, skills, and positive values surrounding sexuality, relationships, sexual health, and wellbeing (WHO, 2016). However, existing efforts in school-based sexuality education in North America, and specifically in the United States have been alarmingly inadequate in fulfilling this definition. Public opinion across North America, and in the United States in particular, has demonstrated strong support for sex education in schools (Barr et al., 2014, 10; Kantor, 2020; Narushima, 2020). However, even in cases where conservative interest groups have failed to oppose, reduce, or eliminate sex education requirements and standards in schools, sexuality education, as is currently taught across the United States, has been found to leave gaps in addressing overall sexual health and well-being. This project seeks to problematize and explore these gaps, especially where sexuality education retains an entrenched focus on youth sexuality as inherently risky, and omissions when it comes to gender, sexuality, racial, and class differences in sexual experiences and diverse knowledge needs (Hollander, 2016; Hunt, 2022; Elia and Tokunaga, 2015; Laureano and Flowers, 2018; Narushima, 2020; Schalet et al., 2014; Willis et al., 2019). When taught effectively, (or taught at all), sexuality education can provide a base level of information and

skills in understanding and practicing reproductive and sexual health. However, vital gaps remain when it comes to equipping American students, and especially non-white or non-heterosexual/cis students for the realities of lifelong sexual development and sexuality.

Survey data from past decades shows a decrease in American adolescents reporting having received formal sexuality education, especially on key topics, such as avoiding sexual coercion and contraceptive use. For example, Lindberg et al. (2016), documented changes in the receipt of sex education among adolescents aged 15-19 years old in the U.S. during 2006-2013, from both formal sources, such as schools, religious institutions, or a community center, and informal sources, such as parents. Using nationally representative survey data from National Survey of Family Growth, the authors found that overall, about one-quarter of all teens reported not receiving any instruction on birth control topics. If not from schools, where are young people accessing this information?

Overall, sexual health topics were more likely to be discussed in school-based sexuality education or not at all, than with a parent. Healthcare providers were not able to fill this gap either, as only 1 in 10 sexually active adolescents who did not receive information on birth control from parents or school reported speaking with a healthcare provider (Lindberg et al, 2016). The Guttmacher Institute (2017) also reported that adolescents' healthcare providers usually do not speak with their patients about sexual health during primary care visits, and when they do, conversations remain brief; on average, sexual health conversations between healthcare providers and patients aged 12-17 lasted 36 seconds (*American Adolescents' Sources of Sexual Health Information*, 2017). Interestingly, Lindberg et al., (2016) compare their findings of declining formal instruction on sex education, including on contraception, with declines in teen pregnancy in the U.S. related to increased contraceptive use.

These findings suggest that young people across the U.S. are relying less and less on formal sexuality education, parents, and healthcare providers and increasingly on their own informal networks and resourcefulness. Despite the gaps in formal education, it is important to recognize that youth are still learning about sexuality and reproduction outside the classroom. Some studies have deliberately explored where youth are accessing sexual and reproductive health information ("American Adolescents' Sources

of Sexual Health Information," 2017; Narushima et al., 2020,) and others have uncovered this information by asking about young people's experiences of sexual education (Bishop et al., 2021; Haley et al., 2019; Hunt, 2022). While research on existing curricula and mainstream educational resources and tools provide some insight into the information young people are receiving, a more expansive research focus is needed to accurately understand the current nature of sexuality knowledge transfer, and to move beyond the narrow understanding typical of existing materials of what contributes to sexual wellbeing for all youth.

Additional research is needed that explores sexual health knowledge-sharing that will center youth as the experts of their own experiences and needs, to identify: What communities, sources of information, and pedagogical tools are youth turning to when filling in the informational and social emotional sexual health needs left unaddressed by formal school-based sexuality education? This project will present a qualitative image of where, how, and why youth are accessing sexual and reproductive health learning experiences, knowledge, and support in the context of rural U.S. To meet this goal, the project has used a reproductive justice lens and feminist participatory methods to conduct semi-structured in-depth interviews, followed by focus groups. The testimony received using these methods has provided rich data which allowed for deep qualitative analysis on the experiences of sexuality of four gender diverse youth in Maine, adding unique nuance and insight into the nature of the existing gaps in sexuality education in the U.S.

Foundational to the reproductive justice framework is attention to systems of oppression and the ways in which they impact groups and individuals' relationships to sexual and reproductive health and wellbeing. This includes the social contexts by which sexual and reproductive wellbeing are influenced, and knowledge derived from the lived experiences of individuals, groups, and communities (Flowers, 2018; Ross, 2017; Ross and Solinger, 2017). A focus of reproductive justice is on how individuals and their communities have negotiated institutionalized reproductive oppression and reclaimed reproductive autonomy through informal channels and community-based efforts (Ross and Solinger, 2017). This practice of underserved and exploited populations claiming agency and autonomy to provide sexual

wellbeing and reproductive justice for themselves is also seen in contemporary sex education, wherein youth seek for themselves information denied to them in the classroom, as noted in the literature above.

This project will first set the context for the project by making clear the inadequacy of school-based sexuality education in the U.S. in representing youth sexuality and addressing key informational and social emotional aspects of youth sexual health. This project will ask youth to reflect beyond their experiences of school-based or formal sexuality education, and to identify what it means for youth to practice sexual wellbeing. Sexual wellbeing is a concept that goes beyond understandings of sexual health which remain rooted in biomedical and risk averse understandings of sexuality (Mitchell et al., 2021). Sexual wellbeing positions sexuality as a key factor of overall wellbeing, considering multidimensional factors in one's life, encompassing the physical, as well as the mental, spiritual, and emotional realities of sexual development, as well as how they're impacted by sexual and reproductive oppression. This thesis will explore how sexual wellbeing is conceptualized and experienced by youth in the context of Maine.

The analytical lens, methodology and methods are outlined in greater detail below. The central question this thesis seeks to address is: What contributes to youth sexual wellbeing in Maine?
To address this question, the study considers:

1. How do Maine youth understand and engage with their own sexual wellbeing?
2. What barriers do Maine youth face to practicing sexual wellbeing and what supports do they access to overcome these barriers?
3. What are the enabling factors that allow Maine youth to practice sexual wellbeing?
4. What are the informal sources of sexual health support (peers, partners, youth groups, the internet, etc.) that Maine youth are accessing to help fill in possible gaps left by sexuality education?
4. How can service providers, educators, community organizations, and advocates better integrate youth knowledge and experiences of sexual wellbeing into larger conversations on strategies for reproductive and sexual justice in Maine?

The significance of this research cannot be overstated. The overturning of Roe v. Wade by the U.S. Supreme Court in 2022 marked the final erosion of what scant federal legal protection reproductive healthcare had in the U.S. Roe v. Wade provided a negative right to abortion, which, rather than entitling U.S. citizens to abortion access, meant that the state could not prevent abortion for those who could readily access it. After being gutted in 1976 by the Hyde Amendment, which prohibited federal funds, including public medical insurance from going towards abortion, and after 1992 restrictions on abortion access were upheld by the Supreme Court, Roe v. Wade was already largely inadequate in ensuring abortion access, particularly for marginalized groups (Johnson, 2022; "The Hyde Amendment", 2021). Conservative interest groups were emboldened with the election of Donald Trump in 2016 to speak out and make moves to criminalize perceived threats to normative family values in the U.S. Targets of these moves have been reproductive healthcare and LGBTQ+ acceptance, especially as they intersect with race and class. These policy moves go directly against public opinion, which supports abortion and LGBTQ+ acceptance (Price, 2018; *Public Opinion on Abortion*, 2022). Thus, the overturning of Roe v. Wade, while a devastating blow to reproductive justice, comes as no surprise, marking an extension of the influence of anti-abortion and anti-LGBTQ+ right-wing lawmakers following the 2016 election.

Attacks on sexual and reproductive health and rights disparately impact rural populations in the U.S. In their study on adolescents' receipt of sexual health information from 2006-2013, Lindberg et al., (2016) noted that declines in formal instruction on all topics was concentrated in nonmetropolitan areas in the U.S. The authors express concern for this trend, citing the concurrence of disparately high levels of teen pregnancy, low levels of access to sexual and reproductive healthcare, and lower public-school capacity in rural areas. Further, rural areas tend to be those with widespread populations who identify with conservative values and are slower to adopt progressive views than urban counterparts (Gimpel et al., 2020). Under these considerations, Maine presents a unique case study, in that it is the most rural state in the U.S.; Of Maine's total population of 1.3 million, 61% live in rural areas, yet demonstrate consistent progressive values (Raymond et al., 2008; "U.S. Census Bureau," n.d.). Even after Roe v. Wade was overturned, Maine law protects abortion access statewide. Further, in 2023, the Maine legislature moved

to expand access to abortion by removing all restrictions to the procedure, converse to trends in other rural states (Sharp, 2023). Maine offers an unusual blend of rural values of self-reliance, tradition, and tight-knit communities, liberal leanings, and a very active network of advocates, activists, organizers and practitioners in sexual and reproductive health, LGBTQ+ health and rights, domestic and sexual violence prevention, and youth programming. This is a network which I have had the privilege to work within. Thus, Maine, as a rural progressive state, presents a case study which I have the connections to explore appropriately and in-depth, and which offers both a demonstrated need for attention to sexual and reproductive health and education access, as well as a welcoming culture and safety for both researchers and participants carrying out research on these subjects, which may not have been the case in other rural states.

This project will discuss how conservative interest groups and their deliberate reproduction of oppressive social values have limited widespread access to comprehensive classroom-based sex education in the U.S. The research will situate contemporary debates on the effectiveness of sexuality education in schools in the larger context of school-based, state-sponsored sex education as a tool of reproductive oppression. As will be discussed in the literature review, current political debates on what should be included or not included in sexuality education are far removed from established evidence on best practices in sex education. This project acknowledges that the role of the U.S. political sphere has been at best, inadequate, and at worst, antagonistic in fulfilling sexual wellbeing needs in channels of formal sex education. In this project, young people reflected on their needs, experiences, and sexuality outside of the discussions typically taking place in sex education classrooms and spoke of the realities they face as they engage with sexual wellbeing under a federal government and growing alt-right conservatism in a context where access to information, resources, support for their wellbeing are nonexistent or under threat.

This project offers novel insights into both how young people in Maine conceptualize sexual wellbeing and the factors in their lives which have been integral for them in practicing sexual wellbeing. The research opens a discussion on the role of “safe spaces” in young peoples’ practice of sexual wellbeing and the ways in which having spaces where youth feel comfortable and safe being and

expressing their authentic selves have the potential to create effective learning environments for young people as they explore topics related to sexuality. In Chapter 4, results show how participants feeling safe and respected was a prerequisite to them being able to learn, process information, and access sexual health support and services. "Safe spaces" were those spaces where the young people in this study felt that, regardless of their identity(s), they were welcomed, accepted, and respected. Participants described how such spaces could be created when mainstream norms surrounding sexuality, such as fear, prescriptive attitudes, shame, judgement, or silence, are subverted in favor of norms of inclusion, openness, acceptance, nonjudgement, or solidarity. These insights offered by the four participants of this study illuminate a need to explore the idea of "safe spaces" as a potential factor with more universal importance in enabling youth to explore and practice sexual wellbeing.

Moreover, in discussing learning experiences which contributed to sexual wellbeing, the young people of this study emphasized the concept "sex neutrality" or "normalcy," as an effective guiding principle on discussions of sexuality, in which sex is treated simply as part of the human experience. The study participants also disavowed the idea of effective school-based sex education or the promise of one all-encompassing curriculum by pointing out that understanding ones' sexuality is a lifelong process of exploration, which cannot be covered in a singular course in ones' adolescence. The discussions of "safe spaces", sex normalcy/neutrality, and sexual wellbeing as a lifelong learning process introduced by the youth in this study contribute to larger discourses in both scholarly literature and sexual health and education practitioners (i.e., providers, educators, curriculum designers, advocates) on reimagining what lifelong sexuality education may look like beyond existing models, and its potential to contribute to youth sexual wellbeing.

Contributions and major insights offered by this project will be discussed in greater detail in Chapter 5: Conclusion and Recommendations.

Chapter 2: Literature Review

Overview

The literature review section will first present the current context of sexuality education in the U.S. to offer appropriate background on the nature of discussions on youth sexuality as they are outlined in curriculum and take place in sex education classrooms across the country, as well as in the State of Maine specifically. The literature review uncover why curriculums have remained centered around demonstrably ineffective guiding principles such as abstinence and limiting youth's sexual behaviors, despite widely known best practices. In answering this inquiry, the review will situate these ineffective and harmful principles found in American curriculums and classrooms within the historical context and current evidence of public school-based sex education in the U.S. as a tool of reproductive and sexual oppression by the state. The review will then discuss the inadequacies of school-based comprehensive sexuality education in more detail, explore how young people have been filling in the gaps on their own, and introduce sexual wellbeing as a concept which has the potential to address the current gaps in sexuality education.

The theoretical framework invoked will offer a further elaboration on the role of racial and class hierarchies, patriarchy, and heteronormativity in establishing and maintaining the "desired" population of the nation-state by enforcing the heterosexual nuclear family as a social structure through the American sex education classroom. The review concludes that because sexuality education under state jurisdiction fits into this larger system of government population control, the lack of relevant information and the inclusion of harmful narratives, rather than being an oversight of school-based sexuality education, is by design, serving its purpose as part of reproductive and sexual oppression. This claim provides a justification for the project itself to turn away from a focus on formal public school-based and state efforts in promoting youth sexual wellbeing as ineffective channels designed for reproducing social hierarchies rather than promoting wellbeing. Finally, before moving on to Chapter 3: Methods, the literature review section introduces and offers an overview of the methodology guiding the creation, design, implementation, results, and analysis of the study.

Current Overview of Sexuality Education in the U.S.: Abstinence-Only vs. Comprehensive Sex Ed

The content and manner of sexuality education varies widely across the U.S., state to state, county to county, between school districts, and even within classrooms, as requirements are determined at school board and district levels and are influenced by instructor bias, fear of community response, and availability of classroom resources (Elia and Tokunaga 2015; Landry et al., 2003; Lindberg et al., 2016). Despite the lack of consistency in instruction, there are some foundational sex education strategies observed across curricula. To analyze some of the common strategies, I draw on the scholarship and the distinctions made between abstinence-only education (AOE) and comprehensive sexuality education (CSE). It's important to note that although AOE and CSE are generally used to distinguish sex education programs in the U.S., most programs do not fit into either category exactly, and are more likely to fall into a spectrum between the two, with elements of both included (Elia and Tokunaga, 2015). Further, examining sex education standards, policies, or curriculums can only suggest what might be taught in classrooms across the country because of disparate funding for public schools across states and the influence of local jurisdiction in selecting and approving curriculum (State Profiles, 2022).

AOE or abstinence-only-until-marriage (AOUM) education will, going forward, be used interchangeably to refer to sexuality education that:

> teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity… that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects, and …the importance of attaining self-sufficiency before engaging in sexual activity.

as quoted from the U.S. federal funding policy adopted in 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (Elliot, 2014, p. 211; Santelli et al., 2017, p. 234). It's noted in the literature that health professionals or others may describe AOE as sexuality education that emphasizes delaying or refraining from sexual activity as a desired adolescent behavior; however, whether the messaging used is centered around social standards or prescribing teen behaviors, AOE as its taught in sex education classrooms carries the message that having sex is an undesirable behavior for adolescents (Elliot, 2014; Santelli et al., 2017).

Beginning in 1981 the U.S. federal government began funding abstinence education through community and faith organizations, and beginning in 1996, states began to receive funding through the Title V AOUM welfare reform program. This funding for AOE required the exclusion of other information, defining "abstinence education" as programs which "have as their 'exclusive purpose' the promotion of abstinence outside of marriage," meaning they "could not in any way advocate contraceptive use or discuss contraceptive methods except to emphasize their failure rates" (Santelli et al., 2017, p. 274). In 2004 a damning report from the House Committee on Government Reform demonstrated that 11 of the 13 AOUM education programs most widely supported by federal funding "contained false, misleading, or distorted information about reproductive health, misrepresentations about the effectiveness of condoms in preventing sexually transmitted infections (STIs) and pregnancy, as well as gender and sexual minority stereotypes, moral judgments, religious concepts, and factual errors" (Santelli et al., 2017, pp. 274-275). In response to the condemnation of AOE programs by health professionals and reports on ineffectiveness, nearly half of states refused federal funding or AOE programs in 2009. In 2010, Congress created the Teen Pregnancy Prevention Program, as well as the "Sexual Risk Avoidance Education" program, which instructs students on "'voluntarily refraining from nonmarital sexual activity' and teaching the 'benefits associated with self-regulation' and 'success sequencing for poverty prevention,' which is outlined as 'completing school, securing a job, and marrying before bearing children'" (Santelli et al., 2017, p. 275). Following the creation of these programs, federal funding for sexuality education became divided between AOUM and sexual risk avoidance programs approaches such as the Personal Responsibility Education Program and Teen Pregnancy Prevention Programs which are considered "comprehensive" but still must include abstinence as the desired outcome (Santelli et al., 2017).

An expansive and iterative body of literature describes the failings of AOE. Researchers note that abstinence-only education has little effect on delaying sex, the number of sexual partners one has, the use of birth control methods and condoms, whether adolescents go for STI testing, and also promotes discrimination and inequality, as its lessons often contain homophobic, sexist, racist, classist, and ableist

ideas (Clark and Stitzlein, 2018; Elia and Tokunaga, 2015; Elliot, 2014; Santelli et al., 2017; Schalet et al., 2014). Further, there has been little connections made between the psychological harm described to be caused by premarital sex in AOE and actual instances of adolescent sexual activity. Rather, psychological harm has been found to be caused by adverse sexual experiences of abuse, coercion, and violence, as well as the stigma and shame caused by cultural norms surrounding adolescent sexual activity, which are notably perpetuated by AOUM sexuality education (Santelli et al., 2017).

> Comprehensive sexuality education, defined by SIECUS, refers to:
>
> Science-based, medically accurate and complete, and age, developmentally, and culturally responsive sexual and reproductive health information that enables individuals to make decisions about their bodies and futures that suit their unique experiences… taught by trained educators sequentially throughout students' school years and includes information and skills-development related to a range of topics including: consent and healthy relationships, anatomy and physiology, puberty and adolescent sexual development, gender identity and expression, sexual orientation and identity, sexual health, and interpersonal violence (*Comprehensive Sex Education*, 2021, p. 2).

This definition was published in 2021. The definition of CSE has evolved over time and tends to differ in each article on sex education in the U.S. CSE has been most commonly used as a catch-all term over time to refer to sexuality education that moves beyond AOUM and includes sexual health information, whether it's on contraception, condoms, STI/HIV prevention, decision-making, or all of the topics named in the definition above. Data presented by Goldfarb and Lieberman (2021) indicates that 40% of school districts across the country have adopted standards of CSE along with seven topic areas: consent and healthy relationships, anatomy and physiology, puberty and adolescent sexual development, gender identity and expression, sexual orientation and identity, sexual health, and interpersonal violence (Goldfarb and Lieberman, 2021, p. 14). These 2020 standards are the most recent development of the 1991 SIECUS Guidelines for Comprehensive Sexuality Education from Kindergarten through 12th Grade (K-12), which

was the first national framework for the topics and skills that should be included in sexuality education for students at all grade levels (Goldfarb and Lieberman, 2021).

Compounding evidence points to the widespread effectiveness of CSE in K-12 education in modifying youth behavior, contributing to delays in first sexual activity, fewer sexual partners, less unprotected sex, increased contraceptive use, and better academic outcomes (Young et al., 2022, Goldfarb and Lieberman, 2021). One of the major outcomes of CSE found in the review was increased knowledge and acceptance of gender and sexual diversity. Curricula designed to reduce homophobia and teach about LGBTQ+ identities and experiences were largely successful across grade levels, as LGBTQ+ students at schools where LGBTQ+ inclusive curricula was taught reported feeling safer in school environments and experiencing less harassment. Further, the review found that among all ages, including children as young as preschool age, curricula that focused on addressing systems of power, such as anti-oppression, social justice curriculum, or gender transformative approaches, were much more effective in addressing gender norms, gender equity, and discrimination, and reducing unintended pregnancy and STI rates than general CSE curricula (Goldfarb and Lieberman, 2021, p. 19). Goldfarb and Lieberman (2021) also found strong evidence that instruction on dating and interpersonal violence, bystander intervention, and healthy relationships have a large influence on attitudes, skills, knowledge, and behavior surrounding dating and interpersonal violence, as students at schools that implemented dating violence prevention education reported 25% less psychological abuse, 60% less sexual violence, and 60% less physical violence with a current dating partner.

The Paradox of Sexuality Education in the U.S.

Public opinion surveys have shown significant support for comprehensive sexuality education instead of, or in coordination with AOE programs. Landry et al. (2003), analyzed survey data from over 1,600 health educators in determining the deciding factors of what is included in sexual health education. Public opinion played a significant role. It was found that in 1999, there was notable and documented

support for sexuality education in high school (93%), as well as middle school (84%) (Landry et al, 2003). In 2008-9, survey data revealed that 79.3% of parents supported age-appropriate sexuality education, with 40.4% expressing support for CSE, compared to 23.3% support for AOE (Barr et al., 2014). The same survey revealed most parents supported comprehensive sexuality education, including instruction on communication, anatomy, abstinence, HIV, and gender and sexual orientation in elementary school. Over 60% of parents supported these same topics, plus instruction on contraception and condoms in middle school (Barr et al., 2014). A more recent survey by Kantor et al. (2020) conducted in 2018 for 1,001 likely voters revealed that 89% believed it is important to teach sex education in middle school and 98% highlighted the importance of teaching sex education in high school (p. 244). Kantor's survey on support for sex education in schools also disaggregated results based on political affiliation and sex education topics. The results revealed that there was strong public support from both sides of the political aisle, with over 80% of both sides supporting sex education in both middle and high schools. Most voters (74.4%) also support public funding for programs "both encouraging teens to postpone sex and providing teens with information about birth control and protection from sexually transmitted infections" (p. 247). Support did vary by topic and political partisanship, where those who identified as Democrats were much more likely to support including birth control methods, consent, healthy relationships, and sexual orientation, and Republicans were much more likely to support the inclusion of abstinence (p. 245).

Landry et al. (2003) reported that in 1999, 51% of sex education used "what might be called a comprehensive approach," with regional variations, as Southern states had higher proportions of instructors teaching abstinence-only (30%) than the Northeast (17%) (p. 264). Young et al. (2022) found a decrease in instruction in key CSE topic areas from 2008-2018 including communication, decision-making, and accessing information, particularly in middle school education programs. Despite the well-documented positive outcomes of specially designed CSE lessons and widespread public support for CSE in general, access to these programs remains limited across the country. Meanwhile, AOE, despite its known weaknesses and limitations, has retained federal funding for decades, and the educational material

students receive in classrooms remains far removed from anti-oppressive dialogues and the standards outlined by SIECUS. So why then, does it appear that we are moving backwards? Despite significant and consistent public consensus in support of comprehensive school-based sexuality education since 2003, state policy and the education received by American adolescents lag far behind in reflecting constituent values and mounting evidence, as AOE remains a fixture in many U.S. schools.

To explain the paradoxical state of sex education in the U.S., we must turn to a broader view of the American political, social, and cultural climate, and examine the historical influences of contemporary sex education. Slominski (2020) writes about the beginnings of formal, public sex education with the creation of the Social Hygiene Association in 1914. This marked the merging of the interests of Protestant social purity moralists and doctors and public health officials, towards teaching a focus on disease prevention and the "moral dimensions of sex" (Para 5). Illustrating this, Elia and Tokunaga discuss how in the 20th century, formal public sex education promoted messaging that "[s]exuality was considered dangerous, and the job of sexuality education was to tame and contain it to its 'rightful place' in American society − the marital bedroom. This necessarily meant that sexuality education focused heavily on the virtues of reproductive sexuality, and all else was mostly ignored" (p. 107). Slominski goes on to describe how sex education evolved into "family life education" by the 1960s and remained rooted in religious morality, advocating against premarital sex and other sexual "deviancies," messages that continue in contemporary sex education. The sex education that arose in the 1970s included information on contraception and protection from STIs, driven by fears of widespread teenage pregnancy (especially among Black girls), and HIV/AIDS (especially among young gay men) (Bishop et al., 2021; Elliot, 2014). However, sex education soon became the focus of divisions between conservatives and liberals, with conservatives turning towards AOUM programming, centralizing and cementing the role of personal responsibility, sexual morality, and individual decision-making in sexuality education as part of a broader regime of neoliberal consensus took hold in the U.S. Tracing this history showcases the continuity of themes of morality, fear, and prescriptive social sexual norms within American sex education, demonstrating how AOE aligns with these foundations of state messaging on sexuality, and providing

background on why these ideas remain present in today's policies, standards, curriculums, and classrooms.

The literature also emphasizes the role of neoliberalism in the entrenchment of AOE within current sexuality education in the U.S. Elliot (2014) defines neoliberalism as "a mode of governing, a cultural project, and economic strategy… [which] advocates minimal government economic regulation, privatizing state resources, and distributing social services through the market… As a mode of governmentality, neoliberalism emphasizes individual choice and autonomy, stressing the importance of self-regulation and enacting harsh punitive measures for 'bad' choices" (p. 212). The political, social, and cultural impacts of neoliberalism are evident in contemporary America. Over the last decades, income inequality has risen dramatically, and public welfare needs are answered with carceral solutions, as poverty is criminalized and punished as an individual failing, and individual responsibility and self-reliance are seen as determinants of success, while gender, race, class, or sexual hierarchies are ignored (Elliot 2014). Elliot (2014) situates federal support for abstinence-only education within the economic consequences of the Personal Responsibility and Work Opportunity Reconciliation Act and its promised "welfare reform." This neoliberal reform restricted access to welfare based on stricter work requirements and time limits, and deregulated banking and other industries, causing accelerating economic inequality. Neoliberal economic policy relies on the mainstreaming of neoliberal social and cultural understandings of inequality, deferring accountability for the resulting poverty from the decline in the accessibility of public support towards "personal responsibility" (Elliot 2014). AOE and the sexual standards it espouses are a key piece in tying together the economic, cultural, and social foundations of American neoliberalism. AOE emphasizes the narrative of the personal responsibility Americans have in self-regulating their sexual behavior to secure their economic future, teaching that those who deviate from sexual norms will suffer the consequences of poverty, irrespective of systemic oppressions related to gender, race, class that impact Americans' quality of life and access to vital resources.

Therefore, the literature demonstrates how sexuality education fits into a larger system of governmental population control, in which sexual behavior comes under state jurisdiction, and sex

becomes a gendered, racialized class privilege. Those who achieve the stability of the financially sound nuclear family are able to enjoy their sexuality, and those who deviate from the "expected standard of human sexuality" are a product of their own moral failings, have diverged from the path of economic stability, are undeserving of public aid, and are bound to no longer reach the ultimate neoliberal goal of "self-sufficiency" (Elliot, 2014, p. 211; Clark and Stitzlein, 2016). Under neoliberalism, over the past decades, sexuality education, and specifically AOE has become a tool of enforcing and reproducing race, gender, class, and sexual hierarchies, while masking their impacts with narratives of personal responsibility. An article by Clark and Stitzlein (2016), aptly named "Neoliberal narratives and the logic of abstinence only education: Why are we still having this conversation?" the authors ask "how - despite a lack of support and evidence - abstinence-only education maintains such a stronghold in America's public policy and consciousness?" (p. 322). The authors argue that because AOUM advocates have been successful in rooting their programming in historically rooted cultural norms, such as morality, individual responsibility, and personal freedoms, these programs remain upheld by "[a] small and savvy group of conservative politicians outside the deliberative realm," who normalize health-based systems of oppression alongside economic and power inequalities within the American psyche and, as a result, American classrooms (Clark and Stitzlein, 2016, p. 329).

Thus, despite widespread knowledge and support surrounding the best practices for sexuality education in the U.S., state institutions retain decisive influence in whether these best practices reach classrooms and students, leaving implementation scant and hard fought against conservative minority interests. Efforts to improve sexuality education in the U.S. through political channels is subject to the obstacles of various, disparate, federally funded, and locally governed programming. The power of the U.S. state in reproducing oppressive hierarchies and effectively censoring vital information surrounding human sexuality is rooted in a political will that is "outside of the deliberative realm," held by well-funded conservative interest groups, rather than the public interest. This is decidedly not the realm in which positive change for youth sexual health is taking place, as policy improvements when they do occur tend to be lagging behind known sexual health and education best practices, and subject to overturn

as elections occur. Moreover, Elliot (2014) notes how even when CSE is implemented, elements of individual responsibility and morality, prescriptions of sexual behavior, and the reproduction of gender, class, and racial hierarchies all tended to be present, although sometimes more subtly, in CSE curriculums and classrooms, indicating that even the "best" practices in U.S. sexuality education may be lacking still, what is known to contribute to healthy sexuality. The next sections of the literature review will examine critiques on CSE in more detail.

Biomedical and Risk Averse Framing in CSE

While CSE, as a strategy, offers a much more comprehensive (as the title suggests) approach and is linked with better outcomes in reduced pregnancy rates and STI risk than AOE, growing evidence demonstrates that the oppressive standards of accepted sexuality which are the centerpiece of AOE, can also be found more inconspicuously in CSE programming. Elia and Tokunaga (2015) use critical pedagogy to examine the way that heteropatriarchal messages are reproduced even in evidence and fact-based comprehensive sexuality lessons, using the example of the definition of "sex." In comprehensive sexuality education, sex is often defined biomedically using binary terms, and the role of each of the "opposite sex" in reproduction is emphasized (Elia and Tokunaga, 2015). This narrow and technical method of introducing sex education perpetuates the longstanding focus of U.S. sexuality education on sex for reproduction and gender roles within this model. This definition has implicit exclusions, including realities of gender diversity, body diversity, sex outside of reproduction, non-penetrative sex, and LGBTQ+ sex. By introducing sex in this way, inequities are reinforced from the very start for those who are left out of that specific script and blueprint for what sex is, who it is for, and how it should go.

This is corroborated in narratives of lived experience provided by youth in the study by Haley et al., (2019), where youth expressed that "they did not realize that there are other types of sex in addition to penile-vaginal sex… [and] sex education curriculum had ingrained in them that 'sex was defined as a penis and a vagina inserting into each other'" (pp. 1839-40).The approaches within CSE are also known

for discouraging sexual activity rather than discussing what constitutes a healthy sex life (Goldfarb and Lieberman, 2021; Elliot, 2014). Yee (2010), notes how by limiting conversations in sexual education to reproduction and sexual risk avoidance, "existing programs often frame adolescent sexuality as dangerous," and stop short of engaging youth as "empowered subjects interested in sexual pleasure" (Yee, 2010, p. 23). Goldfarb and Lieberman (2021) acknowledged that in their wide review of CSE literature, that pleasure and desire were seldom mentioned and despite CSE being portrayed as the binary opposite to AOE, it remains that among both, youth are denied agency and "most sex education is focused on sex as a problem behavior" (p. 23). One of the major weaknesses of the CSE approach is a focus on prescribing teen behavior and teaching general health skills and facts, without larger discussions of the sexual health needs and realities of young people and its connection to their overall wellbeing.

Elia and Tokunaga (2015), echoed by Santelli et al. (2017) and Schalet et al., (2014), point out that the risk averse and biomedical framing in sex education cause discussions to center around a narrow definition of what sex can be, and positions risk as a result of individual decision-making in relation to immoral sexual deviance. Elia and Tokunaga (2014) point to the following factors including "relationships and the influence of others, entrenched belief systems, power within the context of social and sexual relationships, just to name a few, [which] make complete autonomy nearly impossible…. Simply providing youth with 'the facts' about sexuality, as defined by physicians, public health educators, and teachers, is not accounting for the larger structural systems that influence decision making such as legal systems, religious beliefs, cultural practices and political institutions" (p. 113). Adolescents do, in fact, face sexual health risks and adverse effects, as initiation of sexual intercourse in adolescence places youth at an increased risk for STIs and unplanned and/or unwanted pregnancy, but these risks and impacts are "as much the result of environmental factors as individual choices" (Santelli et al., 2017, p. 275). Treating sex as a taboo topic also impacts adolescents' ability to feel comfortable discussing sexual and reproductive health openly, leaving them ill-equipped to exert autonomy in their relationships (Yee, 2010). In this way, the framing within CSE of youth sexuality as a risk-taking behavior which can be

controlled through decision-making skills also reinforces the same cultural and social neoliberal values as AOE.

Moving beyond measuring the topics or skills covered in school-based sex education classes and the extent to which they prevent or delay youth sexual behavior, many qualitative studies explore the emotional impacts on youth by asking students to reflect on their lived experiences. These studies are revealing in that they go beyond measures of students' sexual behaviors such as pregnancy or STI rates and explore the impacts of the risk-averse or "prevention" framing of youth sexuality education on the social emotional and psychological wellbeing of students. When a program's success is measured on whether it discouraged students from engaging in sexual activity, rather than improving youth sexual health, fear, stigma, and shame are often employed as teaching tools, despite their harms to young peoples' sexual and overall wellbeing.

Evidence of the use and impacts of fear, stigma and shame is illustrated in interviews conducted with 20 undergraduate students aged 18-23 years on their experiences of Ohio's school-based sexuality education. In this study by Hunt (2022), three key patterns of sexuality education were identified: sex negativity, the exclusion of LGBTQ+ individuals, and major gaps in information that students had to fill on their own. Hunt describes students recalling feeling frightened in class, as well as outside of class, with messages of fear, shame, and caution surrounding sex, STIs, and interpersonal relationships, preventing them from speaking about anything related to sex with their families or peers. As the author documents, "one student described the thought of engaging in sexual behavior in high school as 'debilitating'" because of fears relating to premarital sex (p. 7). Some students interviewed even laughed when they were asked if their sex education courses talked about LGBTQ+ individuals, and some discussed feeling "abandoned and ashamed," and recalled gay or lesbian friends being removed from class or transferring schools because of harassment faced for their identities (p. 8).

Ultimately, Goldfarb and Lieberman (2021) conclude that "most sex education is focused on sex as a problem behavior. The literature suggests that there is a need for, but little evidence of, teaching that views teen sex as normative, rather than pathological" (p. 23). They emphasize how leaving this need

unfulfilled “eliminates the opportunity for young people to explore and experience normal, healthy, safe, and pleasurable sexual activity” (p. 23). The literature asserts that biomedical and evidence-based comprehensive sex education can provide students with important skills and vital knowledge of STIs, healthy relationships, and contraception, but leave many aspects of students’ lived realities of sexual development, such as pleasure, community, intimacy, and emotion out of sexuality education entirely or tacked on to existing lessons as an afterthought. These glaring omissions and prescriptive narratives in CSE leave students ill-equipped for practicing healthy sexuality, and also have been documented to be detrimental to young peoples’ wellbeing.

Exclusion, Discrimination, and Inequity in Sexuality Education

Even in CSE, programming which covers the diverse realities of human sexuality, and the economic, social, and cultural contexts which shape experiences of sexuality, remains rare. Elia and Tokunaga (2015) point out that, “largely missing from many of these educational programs are discussions about larger social contexts and factors that play in the development of individual sexual identity and of disparities in sexual rights, freedom, and expression of certain minority groups (such as LGBTQ, youth of color, and youth with disabilities)” (p. 108). The authors also note that that “While some resources are more progressive in terms of including diverse and frequently overlooked populations, present-day sexuality education is largely unstructured, inconsistent and based upon individual, familial and community morals of heteronormativity” (p. 109). Further, class, or socioeconomic status, plays a large role in the sex education received by young people and their health outcomes as a result. Lindberg et al. (2016) note that household income has a large impact on adolescents’ receipt of sexual health information, noting how “[p]oor teens are more likely to live in impoverished neighborhoods, with lower school quality and less access to health services, and to have higher rates of STDs, teen childbearing, and early onset of sexual activity” (p. 626).

Beyond wide inequities between schools and among curriculums, the classroom itself, no matter what is being taught in it, is far from an equitable space for students to learn, and for some is a place where they experience exclusion, isolation, or discrimination. Elliot (2014) emphasizes the role of dominant cultural norms in creating alienation or acceptance for students within the classroom, describing how inequalities are perpetuated, as "elites reinforce and reproduce the status quo through the institution of education by imposing their beliefs, standards, and cultural dispositions as superior and universally desirable" (p. 213), which can be seen more overtly in AOE which specifically prescribes the socially accepted standard of sexuality, but is also present in every sex education classroom.

This is illustrated in the lived experiences of those in the classroom. In the study by Bishop et al., participants reflected on learning that "homosexuality is unhealthy and socially unacceptable," noting that such prejudice is not only present in some curricula but is mandated to be taught in some schools across the country (p. 654). More implicit biases in sexual health classrooms are described by Elia and Tokunaga (2015) and Bishop et al. (2021), where students of color are treated as more "at-risk" and overly sexually active as opposed to their white peers, exacerbating the messages of fear and risk that accompany the sexual health information that these youth receive. These inaccurate, discriminatory, and misrepresentative narratives inflict harm on students and their understanding of reproduction and sexuality. They also bar these students from seeing themselves reflected in their sex education. Goldfarb and Lieberman (2021) also acknowledge that many conversations on healthy relationships, dating, and interpersonal violence leave out LGBTQ+ students, and students with disabilities are left out of sexuality education conversations completely in many cases. As a result, these groups of students are excluded from the positive outcomes found in the authors' expansive review of the effectiveness of CSE. Thus disparities, exclusions, and stereotypes related to intersecting identities of race, sexuality, gender, and ability as well as the harm they cause students, persist in educational curriculum.

There is also an overall lack of intersectional focus in CSE, in representing the experiences of sexuality of all students, but also in accounting for intersecting factors such as gender, ability, class, and race which implicitly impact individual level sexual decision making. These omissions enforce societal

inequities and hierarchies based on race, gender, socioeconomic status, and ability, as they disproportionately leave young people of marginalized identities out of the conversation and ignore the impact of these hierarchies in sexual health outcomes. Elia and Tokunaga (2015) write how even when lessons are written specifically for youth of identities outside of white heteropatriarchal norms, such as students with disabilities, LGBTQ+ youth, racially diverse youth, these lessons are often integrated into existing curriculum. The absence of the representation of these youth in the original curriculum, and their later addition instills the messaging wherein minority youth are outsiders, "others" to whom norms of sexuality apply differently and fails to address the foundational narratives reproducing inequalities within exclusionary curricula. Thus disparities, exclusions, and stereotypes related to sexuality and race, gender, and ability persist in curriculums, unaddressed by additional lessons on inequality, racial justice, or disability and sexuality. Ultimately, the strategy for realizing "the full potential of CSE" begins with "considerations of race, class, culture, ability, socioeconomic status, and other important characteristics" (Goldfarb and Lieberman, 2021, p. 23-24). The authors argue that this intersectional lens must be integrated into all aspects of CSE including curricula, teaching, and evaluation (Ibid, 2020, p. 23-24; Elia and Tokunaga, 2015).

It is also important to mention the exclusion of gender diversity in CSE and the disproportionate need for healthcare and information for gender diverse youth. Because of the omnipresence of the gender binary which denies the existence of transgender (trans) and non-binary (TNB) youth - youth who have a gender identity that differs from their sex assigned at birth - they face disproportionate risk for negative sexual health outcomes, and experience widespread denial of information on their gender and sexuality. Haley et al., (2019), citing data from the 2017 Youth Risk Behavior Survey indicating that trans youth reported engaging in sexual activity before age 13, having had 4 or more sexual partners, and not using contraception or condoms during last sexual intercourse, as well as drug or alcohol use before last sexual intercourse. Further, 27.7% of U.S. trans women and 56.3% of black trans women reported having HIV, and in 2015, of those who expressed having a trans identity between kindergarten and 12th grade, 13% reported sexual assault during those years. Other studies have confirmed that of trans women of color in

the U.S., a majority reported a history of being forced to engage in sexual activity. Haley et al. build on literature which "have shown that early sexual experiences of lesbian, gay, and bisexual youth are different than those of heterosexual youth—including greater risk" of violence and negative health outcomes (p. 1835).

Haley et al. (2019) highlight that "in a recent American Academy of Pediatrics policy statement on comprehensive care and support of transgender youth, children who later go on to identify as TNB reported having felt their gender was "different" at age 8.5 years, on average, although most did not disclose these feelings until 10 years later" (p. 1835). This indicates a large need for discussions on gender diversity and TNB identities during those years when young people are "privately experiencing feelings of gender dysphoria," the feelings of confusion, unease, and pain TNB youth experience particularly during puberty when their biological characteristics don't match their gender identity (p. 1835). Haley et al., (2019) note a lack of available perspectives of TNB youth, parents of TNB youth, and healthcare affiliates of TNB youth on their sexuality education experiences and needs. Their study recruited TNB youth aged 18 and over, parents of TNB and gender clinic staff to participate in semi-structured interviews to explore these topics. The study found that while reflecting on school-based sexuality education, "all youth felt they lacked sexual health knowledge compared with their cisgender peers, and many expressed uncertainty about where to turn to fill in their gaps" (p. 1839). Healthcare providers at the gender clinic expressed having difficulty ensuring TNB youth felt comfortable discussing sexual health with them, quoting "I don't like talking to strangers at all. I 1,000% don't want to talk to you about sex'" (p.1839). The study by Haley et al. (2019) makes it clear that gender diversity and gender identity, and discrimination related to these identities, have large impacts on an individual's sexual health and wellbeing as they undergo sexual development. Therefore, its well documented in existing literature that the state of sex education in the U.S. can be found to be discriminatory, inaccurate, and promoting of oppressive narratives, ultimately failing to equip students with the skills and knowledge needed for healthy sexual development. Consistently underlying this spectrum of what is offered in sex education in

the U.S., is implicit and oppressive standards of acceptable sexual behavior rooted in longstanding messages of sexual and reproductive oppression.

Turning Towards Their Own Communities

Also longstanding, is the practice of those marginalized by sexual and reproductive oppression, denied access to information, education, healthcare, and other basic needs because of their deviance from the State's social standards of sexuality, turning towards their own communities for support. It is important to understand "community" as a fluid term which can denote groups based on identity, social relations, and geography depending on the context in which it is used. For the purpose of this study, one's "community" as it referenced in literature and by the participants in Chapter 4: Results, Analysis and Discussion, refers to the social contexts in which people live their daily lives; encompassing the multiplicity of social roles, relationships, and spaces, within and beyond their households, in which they interact with others. In Bishop et al., 2021; Haley et al., 2019, Hunt, 2022, Lindberg et al., 2016, many youths reported learning more about sex from parents, friends, or media than formal sex education, or feeling isolated when they were unable to connect with family, friends, or healthcare providers to answer their questions. As Hunt noted, "students simply wished to be told more about the reality of sex and sexual encounters…[and] despite the importance of sex education, sexual socialization also happens outside of the classroom" (p. 9).

This is especially true for sexually and gender diverse youth who have suffered from silence in sexuality education on their very existence for generations and have long built their own networks to access critical support and information. In the study by Haley et al. (2019), many youths, parents, and providers cited peers as a source of information and support accessed by trans and nonbinary (TNB) youth, where youth "valued TNB peers' perspectives specifically because 'there's no glossary' for what relationships and sex will be like after starting hormone replacement therapy (HRT)." With peers, TNB youth were able to have conversations "like, 'Is this happening to you? This is happening to me, too'" (p.

1839). However, peers were decidedly not sufficient sources of sexual health information. As one youth reported, they were "a propagator of 'really dumb stuff that my friends apparently believed for years'" (p. 1839).

Additionally, 2015 national survey data revealed that among 7th-12th graders, a majority (55%) have searched for health information online (Lindberg et al., 2016). A report by the Guttmacher Institute published in 2017 suggests that LGBTQ+ students are even more likely to rely on the internet for sexual health information. In a 2010 survey, 65% of bisexual and 78% of self-identifying lesbian, gay, or queer youth reported searching online for sexual health information in the past year. The literature hints at the large prevalence of youth turning towards their communities, peers, or online resources and online searches for information and support and although they were sometimes inadequate or inaccurate, these sources offered them stories similar to their own, support for their identities, and spaces where they feel they belong.

Sexual Wellbeing as a basis for Sexual Health and Education: Filling in the gaps left by CSE

In their study, Elia and Tokunaga (2015) suggest a more "holistic view of sexual health" including aspects like "social sexual health," "emotional sexual health," "spiritual sexual health," and "intellectual sexual health", and warn against simply "'adding things on'" to an already troubled curriculum (p. 117-118). Sexual wellbeing is a concept that encompasses this sentiment. Mitchell et al. (2021), position sexual wellbeing as closely related to sexual health, sexual justice, and sexual pleasure as four pillars of a public health approach "needed to address structural determinants of sexual inequities" (p. 608). However, the authors also note that "the conflation of sexual wellbeing and sexual health obscures the diversity of experiences—not addressed in definitions of sexual health—that people identify as relevant to their broader wellbeing" (p. 608). While sexual health remains focused on biomedical disease and violence prevention, sexual wellbeing includes biological, psychological, social, cultural, and emotional aspects of sexuality and wellness.

Definitions of sexual wellbeing have varied through years of scholarship and developing understandings of the concept; Mitchell et al. (2021), synthesize past definitions and current scholarship in their own framework. They understand sexual wellbeing as a combination of: "sexual safety and security, sexual respect, sexual self-esteem, resilience in relation to past sexual experiences, forgiveness of past sexual events, self-determination in one's sex life, and comfort with one's sexuality" (p. 610). Mitchell et al. emphasize how "[a] sexual wellbeing approach recognizes the transgenerational traumas that mark the unique needs of marginalized people. This recognition then supports the implementation of population health approaches that are anti-oppressive, intersectional, and culturally and contextually adapted" (p. 611). In this way, sexual wellbeing as an approach to sex education can answer the call issued by scholars above for a holistic and intersectional approach to sex education.

Lorimer et al., 2019, in their review of sexual wellbeing conceptualizations and definitions in literature published after 2007, found that sexual wellbeing can be collectively understood as one's perception of their sexual functioning, and their ability to access what they need to function; the authors reference Amartya Sen's capabilities approach to understanding "the ability of a person to live a life they have reason to value" (Sen, 1985; referenced in Lorimer et al., 2019, p. 844). Lorimer et al. also make the argument that sexual wellbeing encompasses this functionality, and capabilities for sexual functioning, in the context of "individual cognitive-affect type attributes (thoughts, emotions, subjective evaluations), but also inter-personal and socio-cultural dimensions" (p. 844). This understanding of sexual wellbeing also addresses the inclusion of relational and external environmental factors, filling a gap demonstrated above, in which systemic and environmental factors are integral to - but often left out of - sexual health framing and education. Thus, sexual wellbeing offers us a way to understand the reality of the lived experiences of young people beyond the heteropatriarchal, white supremacist, and biomedical confines of typical sex education and sexual health discussions. Centering sexual wellbeing in this study allows for the inclusion of subjective, complex, lived experiences, perspectives, and understandings of young peoples' sexuality often omitted or discouraged from being voiced in conversations surrounding sexual health.

The Context: An Overview of Sexual Wellbeing in the State of Maine and Sex Ed Strategies in the Last Decade

The research for this study narrows in on the state of Maine and the recent specific sex education strategies employed statewide. Central to the discussions of sex education in Maine, is this question posed by Fran Mullin, the director of the Family Planning Association of Maine (now known as Maine Family Planning), and one of the founding members of Plain Truth for Maine Youth, a coalition of 35 community-based organizations across the state that formed to oppose abstinence-only sex education in 1996 (Anonymous, 1998, p. 22). Mullin asks: "How could we tell young children whose parents were unmarried or gay that their families were 'harmful to society'?" Building on this important justice orientation, Maine became of the first states to refuse federal funding for Abstinence-Only sexuality education in 2004. Movements such as Plain Truth for Maine Youth rallied 100 youth and community leaders to testify at the Maine statehouse against the censorship of "lifesaving information," in accordance with "an overwhelming majority of Mainers [who] want young people to receive a full range of sexuality-related information." Mullin cited a 1997 poll which revealed that 86% of Mainers agree that "teaching a wide variety of birth control methods including abstinence" is more effective in addressing teen pregnancy than AOE (Anonymous, 1998, p. 22). Today, Maine is also one of the 13 states which requires education on consent in sex education ("Maine State Profile", 2021).

The director of public health in Maine in 2004, Dora Mills, said of Abstinence-Only sex education funding: "This completely violates our comprehensive approach to family life education," a program that had been wildly successful in reducing teen pregnancy from its beginning in the State, from 3000 teenage pregnancies in 1985 – one of the highest rates in the country – to 1600 in 2005, and now 972 in 2021 (Tanne, 2005, 715; *Maine*, 2021). In Maine schools, sex education is required, and has been since 2002, as a part of the "comprehensive family life education" course. While conservative interest groups attempted to challenge this requirement twice in 2005, neither attempt was successful (Raymond et al, 2008).

> According to Maine Law, Comprehensive Family Life Education is defined as education in kindergarten to grade 12 regarding human development and sexuality, including education on family planning and sexually transmitted diseases, that is medically accurate and age appropriate; that respects community values and encourages parental communication; that develops skills in communication, decision making and conflict resolution; that contributes to healthy relationships; that promotes responsible sexual behavior with an emphasis on abstinence; that addresses the use of contraception; that promotes individual responsibility and involvement regarding sexuality; and that teaches skills for responsible decision making regarding sexuality. (Title 22, 2001).

The addition of a definition and required instruction on consent were added nearly 20 years later:

> The secondary course of study must also include instruction on affirmative consent, communication and decision making regarding sexual activity and the effects of alcoholic drinks, stimulants, and narcotics on the ability to give affirmative consent, communicate and make appropriate decisions. For purposes of this section, "affirmative consent" means consent to sexual activity that can be revoked at any time and does not include silence, lack of resistance or consent given while intoxicated (Title 20-A, 2019).

Aside from directly requiring an emphasis on abstinence, visible in these legal definitions is terminology which reflects the narratives of sexual and reproductive oppression present in sexuality education, such as “individual responsibility” and “appropriate decisions” which both allude to underlying messages of what “responsible” and “appropriate” sexual behavior is. Further, curriculum in Maine is not required to be comprehensive or include instruction on sexual orientation or gender identity and must emphasize abstinence. Parents or guardians may also “opt-out” of sex education and withhold their child during instruction (“Maine State Profile”, 2021). The content of sex education material is subject to approval and sometimes selected by school boards, but the material, curriculum, and classroom experience may be influenced by several factors, including community and instructor values and organizations such as Maine Family Planning which develops curriculum and works with educators (Title 22, 2001; Title 20-A, 2021;

Federal Programs Funding Chart, 2019; *Maine Family Planning Annual Report*, 2021). Funding for sex education in Maine is sourced from Federal and State levels and goes both to schools and organizations (Federal Programs Funding Chart, 2019). In the 2017-2018 school year, the most taught topics in sexuality education in Maine schools in grades 9-12 were: Abstinence (95.5%), products and services related to HIV, STDs, and pregnancy (95.5%), healthy relationships (98.9%), and how to correctly use a condom (95.5%) ("Maine State Profile," 2021). However, the content, inclusivity, and accuracy of the teaching of these reported topics is subject to variation.

The lived experiences of Maine students align with the gaps and needs of students described in the literature above. In a study by Nevins and Johnston (2017), the major themes that arose in a discussion of students' lived experiences of sexuality education in public schools in Maine were: missing information, negative and uncomfortable classroom atmospheres, absence of resources available in the larger school community, and the necessity of accessing outside information and support. The study reported that "most sexual education was found to be done at home, with a healthcare provider, or through the student's internet research, as opposed to in the school. Students explained they were seeking safety and anonymity by doing so" (Nevins and Johnston, 2017, n.p.). I return to the gaps and limitations of sexuality education in Maine in my research findings.

Theoretical Framework

This thesis interrogates the current state of sex education through the lenses of reproductive justice, as well as Native feminist, disability justice, and queer theory by examining reproductive and sexual oppression and their persistence in formal sex education. Reproductive justice (RJ) is a theory, framework, and praxis that has existed in practice long before it was named by Black feminist activists and scholars in the U.S. According to Loretta Ross and Rickie Solinger, two of the original scholars/activists to discuss RJ, it includes "three primary principles: (1) the right not to have a child; (2) the right to have a child; and (3) the right to parent children in safe and healthy environments. In addition,

reproductive justice demands sexual autonomy and gender freedom for every human being" (Ross and Solinger, 2017, p. 9). RJ is a reframing of reproductive health discourse through the claim of "a safe and dignified context for these most fundamental human experiences" of sex, reproduction, and parenting (Ross 2017, p. 9). Reproductive justice is the antithesis of reproductive oppression, which is defined in the following way: "[t]he control and exploitation of women and girls through our bodies, sexuality, and reproduction is a strategic pathway to regulating entire populations that is implemented by families, communities, institutions, and society. Thus, the regulation of reproduction and exploitation of women's bodies and labor is both a tool and a result of systems of oppression based on race, class, gender, sexuality, ability, age, and immigration status" (A New Vision, 2005).

Queer theory, in its inception, challenged the dominant system of heteronormativity, and the way socially constructed norms of gender and sexuality exerted regulatory power over societal standards of sex, reproduction, relationships, and family formation (Cohen, 2005; Silver, 2020). Queer theory scholar Cathy Cohen expanded upon this idea to include Black feminist scholarship on intersectionality, a term coined originally by Kimberlé Crenshaw, referring to "the fact that the major systems of oppression are interlocking. The synthesis of these oppressions creates the conditions of our lives" (Cohen, 2005, p. 26). Cohen problematizes queer theory and activism which limits the application of queer theory to only LGBTQ+ individuals, and therefore draws a false binary between those oppressed by heteronormativity and heterosexuals, citing that sexual oppression has never been limited to only LGBTQ+ individuals, but also those "who may fit into the category of heterosexual but whose sexual choices are not perceived as normal, moral, or worthy of state support" (p. 26), and that "heteronormativity interacts with institutional racism, patriarchy, and class exploitation to define us in numerous ways as marginal and oppressed subjects" (p. 31).

Disability justice must also be emphasized as a part of this conversation, as people with disabilities have long been subjected to sexual and reproductive oppression in the form of limitations on their sexual and reproductive agency. People with disabilities have also often been infantilized and excluded within reproductive justice activism, particularly due to debates around the right to have an

abortion in the case of prenatal testing which indicates a disability, which is a large reason that disability justice has been portrayed as oppositional to reproductive justice (Kattari, 2023). However, Kattari (2023) asserts that those debates on abortion in the case of disability are rooted in diminutive understandings of both disability justice and reproductive justice, and that any considerations of the two "must start with naming the fact that disabled people deserve full bodily autonomy and the right to... both have children and abortions without facing oppression by the state" (Kattari, 2023, p. 33).

Cohen and Kattari provide a pathway for the "queering" of reproductive justice, a concept that's been referred to commonly in literature which identifies that reproductive oppression and sexual oppression are systems of control and exploitation that work in tandem to dictate dominant norms of sexuality, gender, reproduction, parenting, and family. This understanding asserts that sexuality cannot be understood outside of norms of reproduction, and vice versa (Thomsen and Morrison, 2020). Queer issues and disability justice issues are intertwined with issues of reproductive justice. For example, rights to LGBTQ+ parenthood and parenthood for people with disabilities, access to gender-affirming reproductive healthcare, and rights for LGBTQ+ people with disabilities. Thus, queer theory, disability justice, and the reproductive justice framework can be effectively used in tandem to challenge reproductive and sexual oppression.

To understand the role of state-sponsored heteropatriarchy, reproductive, and sexual oppression in influencing our conceptions and teachings of sex and sexuality, we must also examine the role of U.S. settler colonialism and the foundations of the U.S. nation-state in constructions of norms surrounding gender, sexuality, and their reproduction in schooling, especially sex education. In doing this, I draw from Native Feminist Theory, particularly as described by Linda Tuhiwai Smith (2021), and Arvin et al. (2013). Smith (2021) describes how Western gender roles were constructed within the categories of "men" and "women" along a relational binary which manifested in social institutions such as marriage. These family dynamics were also influenced during the transition from feudal to capitalist modes of industry and production, giving them economic manifestations as well, and creating the gender roles and hierarchies we can still recognize in Western society.

Arvin et al. (2013) discuss the exportation of these values to so-called North America within settler colonialism. They point out the role of heteropatriarchal settler colonialism in marginalizing and erasing Indigenous queerness through the installment and enforcement of European societal constructs of the gender binary and the nuclear family. Arvin et al. (2013) define settler colonialism as a "persistent social and political formation in which newcomers/colonizers/settlers come to a place, claim it as their own, and do whatever it takes to disappear the Indigenous peoples that are there" (p. 12). In the U.S. context, "these simultaneous processes of taking over the land (by killing and erasing the peoples with previous relationships to that land) and importing forced labor (to work the land as chattel slaves to yield high profit margins for the landowners) produced the wealth upon which the U.S. nation's world power is founded" (p. 12). They define heteropatriarchy as "the social systems in which heterosexuality and patriarchy are perceived as normal and natural, and in which other configurations are perceived as abnormal, aberrant, and abhorrent," and heteropaternalism as "the presumption that heteropatriarchal nuclear-domestic arrangements, in which the father is both center and leader/boss, should serve as the model for social arrangements of the state and its institutions. Thus, both heteropatriarchy and heteropaternalism refer to expressions of patriarchy and paternalism that rely upon very narrow definitions of the male/female binary, in which the male gender is perceived as strong, capable, wise, and composed and the female gender is perceived as weak, incompetent, naïve, and confused" (p. 13).

The authors write that the imposition of these power structures "interrupt Indigenous nations' very 'sense of being a people' (Smith, 2005 quoted in Arvin et al., 2013, p. 15), and argue that a key strategy of settler colonialism is the repetition, brutal enforcement, and therefore, naturalization of these concepts as "expressing a 'proper' modern sexuality… a cornerstone in the production of a citizenry that will support and bolster the nation-state" (p. 14). In connecting the oppressive state standards of sexual and reproductive propriety named by RJ theories and queer theories with the very foundations of the U.S. nation-state, Arvin et al. (2013) shed light on the stake of the state and the role of our current political organization and governance systems in controlling human experiences such as sex and sexuality by prescribing these norms within the national public schooling system designed to create model citizens.

The nuclear family as the model of social relationships severs generational ties and flows of knowledge, creates labourers, and drives demand for property, creating the desired market relations to drive capitalist profit creation; the state has vested economic interest in maintaining and consistently reproducing these oppressive settler-colonial social structures (O'Brien, 2023).

In positioning these sexual and gender power structures as human nature, the settler colonial state censors the realities of the land we are on, land which, as Nishnaabeg scholar Leanne Betasamosake Simpson (2017) points out, "provides endless examples of queerness and diverse sexualities and genders" (p. 122). Simpson also points out the way in which queerness is woven into Indigenous societies, saying "when I've asked different Nishnaabeg elders about queerness, they often say that we didn't have that… they will remember stories of queer couples, not as queer people, but just people who lived like that, as something that wasn't a big deal, as if it were a normal inconsequential part of life. What these elders… are describing is a gender variance that existed in many Indigenous communities prior to the strategic implanting of the colonial gender binary" (p. 123). Simpson goes on to describe how "2SQ Indigenous peoples flourished in many Indigenous nations and were highly visible to the first European 'explorers.' The archival and Western historical record sets down this visibility and the anti-queerness of these explorers, translators, traders, and missionaries in the 1600 and 1700s," and the way that heteropatriarchy served these Europeans in their settler colonial mission, through "the destruction of the intimate relationships that make up our nations… the more destruction our intimate relationships carry, the more destruction our political systems carry, and the less we are able to defend and protect our lands, and the easier it is to dispossess" (p. 123). This explanation of the power structures which are foundational to the U.S. as a nation, offers further insight as to why ineffective and harmful sex education policies such as AOE continue to censor knowledge on human sexuality from the American public. Smith, Arvin, and Simpson indicate how queerness is evidence of the Indigenous societies which existed before the nation-state's imposed heteropaternalist patriarchy, and evidence that they have persisted within it. Deviation from the states prescribed sexual norms is dangerous to the survival of the U.S. as a nation, in that it

represents the imagining of an organization of society beyond a binary gendered citizenry, beyond the nuclear family, beyond the capitalist-colonial U.S. nation-state.

Tracing the history of sex education in North America can clearly reveal the ways in which formal, school-based sexuality education developed as a mouthpiece for reproductive and sexual oppression (Bishop et al., 2021; Elia and Tokunaga, 2015; Hall et al., 2016; Lee, 2022; Lindberg et al., 2016; Schalet et al., 2014; Sethna, 1995). Early forms of sex education served to standardize the messaging surrounding reproductive and sexual health and determined who is entitled to sex and reproduction based on the systems of oppression named above, effectively excluding the majority of Americans from fundamental knowledge related to sex and reproduction. Based on the above understandings of reproductive justice, queer theory, disability justice, and Native feminist theories, sex, sexuality, and sexual wellbeing are key factors of reproductive and sexual justice, and the manipulation of these concepts and our experiences of them have been key in maintaining state sponsored systems of oppression. These theories can then offer an effective framework through which sexual wellbeing can be analyzed as it is experienced by young people within these systems.

Methodology

The RJ framework, Dian Million's Felt Theory, and Linda Tuhiwai Smith's body of work on decolonizing research methodologies have heavily influenced both the process of designing the project and the project outcomes. Felt Theory is an Indigenous Feminist Theory which challenges colonial tools of "shame" and "silence" (Million, 2009, p. 54), through the claim that lived experiences offer "emotional knowledges" as events are not only experienced but "felt." The sharing of these personal testimonies in a collective "'bearing witness' is a powerful tool" (p. 56), challenging dominant colonial narratives that ignore emotions and their impact, and characterize systemic oppression as individual failings (Million, 2009). Seeing as the felt experiences of "shame" and "silence" were common in students' retrospective accounts of sexual education mentioned in the literature review above, Felt Theory reinforces the power

and importance of positioning youth's emotions and lived testimonies as key knowledges generated by this project. It also meshes well with reproductive justice, as "storytelling is a core aspect of reproductive justice practice" (Ross and Solinger, 2017, p. 59). In informing my methods I also draw from Smith's (2021) project of storytelling. This project recognizes how "stories are connected to knowing, that the story is both method and meaning and is a central feature of Indigenous research and knowledge methodologies" (Smith, 2021, p. 166).

Drawing from Tuhiwai Smith, alongside existing definitions of sexual health vs sexual wellbeing, centering participants' knowledge and lived experience related to sexual wellbeing, rather than sexual health, can disrupt fundamentally misleading Western cultural notions of the separation of "mind" and "body". This separation treats the mind and body as two distinct aspects of a person, and in so doing obfuscates the impact of mental and emotional states on physical health through their distinctions as two separate fields: physiology and psychology (Smith, 2021, p. 55). As a white settler, it is important that I recognize these as Western ways of knowing. In this project, I consciously seek to challenge systems of oppression and barriers to sexual wellbeing through the methodologies employed in this research. By working with a small sample, meeting repeatedly with the same group of youth to establish relationships with and between participants, and gathering deep and detailed qualitative data on a few individuals, rather than surface level data on many, I move beyond typical measures of sexual health which focus on physical indicators and the absence of disease as well as more widespread explorations of sexual wellbeing, which could have allowed this research to make wider claims about youth sexual wellbeing in Maine.

Through the lenses of RJ, Felt Theory, and Tuhiwai Smith's work, sexual wellbeing can be understood as something holistic that cannot be studied with survey data or statistics, but through a deeper understanding and empathy for peoples' experiences and emotions. Thus, I took deliberate efforts to center the lived experiences and intimate feelings and perspectives of individuals on sexual wellbeing. The centering of storytelling and focus on thoughts, feelings, perceptions, and lived knowledge in this study challenges Western notions of positivism, objectivity, and rationality over emotional knowledges,

and lays a framework for centering the participants voices and self-analysis of their experiences as legitimate and important data and research results.

Chapter 3: Methods

Interviews and Focus Groups

Building on the theoretical frameworks and methodology explained in the previous sections, I deliberately endeavored to choose research methods that uphold the same principles and values, and challenge the systems of power, colonialism, white supremacy, and reproductive and sexual oppression named above. The method of 'focus groups' was selected for this study and the content and direction of the focus groups was informed by one-on-one semi-structured in-depth interviews with each research participant that were conducted prior to meeting as a group. The interviews were conducted before the focus group meetings to avoid limitations to focus group discussions among groups with diverse and intersectional experiences and to ensure that no key topics or themes were omitted.

While focus group discussions are an effective tool for generating discussion and building collective narratives, the conversations can be dominated by more outspoken members, especially when individual participants may be hesitant to discuss sensitive topics, such as sexual wellbeing (Agar et al., 2011). Further, because of the inconsistencies in how sex education is offered, and sexuality is discussed in various community groups, such as family, friends, schools, there was variation in each participants' relationship to - and comfort with - sexuality and sexual wellbeing. There is a risk in the focus group discussions of perpetuating the very same exclusions and biases in sexuality education problematized in the literature review. For example, if individual participants do not see their own experience reflected in the dominant narrative that arises during the focus groups, they may remain silent in group discussion if they feel that their experience does not reflect the research goals. Thus, carrying out the interviews allowed an initial understanding of youth perspectives, familiarity, and their comfort level discussing sexual development, sexuality, and sexual wellbeing, including the initial ideas, feelings, and perspectives of the youth to be established, documented, and analyzed before any influence by group discussions.

In consideration of Maine's rural geography and the large distances between small population pockets across the state, to minimize transportation barriers and costs, prioritize accessibility, and achieve maximum engagement, participants were given the option to conduct their individual interview either online over Zoom or in-person. Three out of four participants elected to have an online interview, where they could choose to have their cameras either on or off, and answer questions from the comfort and safety of their own space. The one participant who chose to have an in-person interview likely would not have been able to participate in the project had interviews only been conducted online. This participant did not have access to stable housing or reliable internet connection at the time of the interview, and I was able to meet them where they were living at the time, at a campground in a rural area of Maine. Because participants were separated by large geographic distance, conducting the focus group sessions online was the only viable option to meet as a group. For this reason, the focus group portion of this study was inaccessible to the participant without reliable internet connection.

The content, format, and activities of the focus group discussions were deeply informed by the data gathered from the interviews. The participatory and collaborative nature of the focus groups is situated within the reproductive justice framework which centers lived experience as knowledge and emphasizes that individual's experiences, choices, and decisions should not be viewed separately from the social contexts in which they take place. Further, allowing participants to work together and build collectively upon their individual narratives in a focus group setting using participatory methods allowed youth to be meaningfully involved, direct and shape open-ended research inquiries according to their ideas, build relationships with myself as the researcher, and one another, and reflect and share their experiences together. My goal in using these methods was to engage youth as researchers and participants, drawing from and analyzing their own experiences as experts on their own knowledge, supports, barriers, and needs in relation to sexual wellbeing. The youth answered questions such as what does sexual wellbeing mean for me? What does it mean for me to practice sexual wellbeing and what experiences have allowed it to happen? Participants were asked to develop a critical understanding of their own lived experience and engage in a process of "collaborative methodological inquiry" (Mirra et

al., 2015, 91). The focus group setting allowed me and the participants to create a collective dialogue through casual conversation so that participants did not feel a spotlight upon them as an individual but rather were able to form a collective identity as part of a group exploring topics that included intimate personal experiences, thoughts, feelings, and perspectives (Malorni et al., 2022). This collaboration allowed for reflections, observations, and analysis to come from participants' own internal thoughts in the interview and again in the focus group, where the discussions were also generated by participants relating and comparing ideas and experiences with one another as a group (Mirra et al., 2015).

As the lead researcher on this project, somebody with facilitation experience, and a youth who grew up and completed all of my schooling in Maine, I was well-suited for facilitating the interviews and focus groups. An unexpected outcome of conducting the interviews and focus groups myself is that I was also not somebody whom some participants pictured conducting research like this. As a young queer, nonbinary individual, participants were able to relate with me in a way that one participant expressed they were not expecting when they agreed to be a part of this project. They talked about how my being another queer young person put them at ease and made them feel like they could speak less deliberately or formally, and more freely. As they expressed: *"I feel really bad for assuming, cause I am not gonna lie, I thought it was gonna be [a] very cisgendered person…I was thinking of a sex ed teacher…so my first thought was... I gotta call them miss or mister... it's gonna be some really old person."*

This was the participant who I met in-person, knowing that they were experiencing homelessness at the time. Because the data collection for this project required authenticity and nonhierarchical relation with participants, I chose to depart from professionalism and formality, and wear my everyday clothes in which I felt comfortably and authentically myself. I began each interview by introducing myself and telling the story of how I came to do this research. For this interview, I showed up to this participant's campsite dressed in a colorful button up shirt, jean shorts, and a baseball cap, deliberately dressed down, as oftentimes it's joked that what is considered formal wear in Maine is your "good" or unripped, unpatched, unstained jeans. We conducted the interview outside at the picnic table next to their tent where they and their partner were living. There was nobody else around, aside from my partner waiting for me

in my car, parked a short distance away, and their partner waiting inside their tent. They gave me bug spray to fend off the mosquitoes and under the sun and surrounded by the sounds of the woods, we sat and talked for about an hour. This was the longest and most in-depth interview of the four, and despite this participant not being able to attend the focus group sessions, their testimony was equally represented in informing the focus group discussions. Additionally, their testimony, while providing perspectives not shared by other participants, did not represent a significant departure from the dominant narratives which came from the group, and much of the ideas, thoughts, and feelings they brought up in their interviews were echoed by other participants in their individual interviews and subsequently in the group discussions.

The focus group structure was modeled on existing focus group toolkits, and primarily the Gender Equality and Empowerment Measurement (GEM) Tool. The GEM Tool is used for conducting community-based participatory feminist research evaluations and was adapted for the context of this research project. The GEM Tool has been designed to use intersectional feminist methodologies to gather meaningful qualitative data and create reciprocal community relations. It aligns closely with the theoretical frameworks described above as it allows participants to direct their own inquiries and directly drive the outcomes of research results based on their perceptions, experiences, thoughts, and feelings, with the facilitator playing an inciting rather than a guiding role in discussions ("Introduction to the Gender Empowerment Measurement Tool", 2022). The GEM Tool was initially designed for use in development project evaluation but can be easily adapted to different settings and goals, such as evaluating sexual wellbeing. It has also been used for both in-person and online data collection strategies and offers toolkits for each technique, so it was a useful model for the focus groups planned for this research.

Recruitment and Data Collection Process

Returning to the main question this project set out to address 'What contributes to youth sexual wellbeing?', this research explored youth voices, through a participatory methodology, and documented experiences of sexual wellbeing through a series of interviews and focus groups with youth spanning from July-August 2023. The details of the data gathering process are outlined below:

Youth were recruited beginning in July 2023. The planning and recruitment of participants for the interviews and focus group sessions was conducted in collaboration with Maine Family Planning, an organization which works across the state with patients, providers, community leaders, and educators, and has conducted focus groups in the past. I took the input and suggestions of Maine Family Planning's Prevention and Education Team into account, and allowed the director of the team, Lynette Johnson, to disperse my recruitment materials to her contacts within youth-serving organizations. Social media use is nearly universal among youth and spans diverse youth populations, and while platforms and level of engagement vary according to the user, among the 18-22 age demographic, Instagram and TikTok are the most popular social media platforms (Barnhart, 2022; Kia-Keating et al., 2017). Accordingly, the recruitment poster was also posted to the Maine Family Planning Instagram page.

The recruitment criteria for the individual interviews and focus group sessions included youth aged 18-22, who had attended elementary, middle, or high school in the State of Maine and were willing to reflect on their experiences of sexual development and sexual wellbeing. The age range of participants was selected for two reasons: 1. 18 year olds are able to sign their own consent forms and can make informed decisions on their own about participation; and 2. While youth development and experience is largely variable between the ages of 18-22, impacted by attendance of college, living on ones' own for the first time, and more expansive experiences of adulthood from age 18 to 22, these are youth who are finishing or have finished high school, but are still able to identify with, but also reflect upon, their experiences of sexual development through a more experienced lens. Including youth who may have finished a college degree with new high school graduates can create hierarchies and discomfort within a focus group as age and perceived age can impact interpersonal dynamics among group members, which is why the suggested age difference among participants is 1-2 years (Kennedy et al., 2001). However,

standards for student learning in sexual education classes are based upon youth sexual development and learning benchmarks are divided by three or four grade levels at a time, i.e. 6-8, 9-12 (National Sex Education Standards, 2020). In addition, because discussions of sexuality can be extremely limited in high school settings, as noted by the literature, older youth may have moved into spaces and situations where these discussions are more commonplace, and support is more readily available. Therefore, older youth could be better equipped to discuss sexual wellbeing having had more time to access support and services, and the voices of more recent high school students in the group will situate this group reflection in the current realities of what it's like to attend high school in Maine, as their own experiences will still be fresh in their minds.

Further, participants between the ages of 18-20 will have had their high school experiences impacted by interruptions in schooling due to the COVID-19 pandemic, while those aged 20-22 will not. This division among group experiences can provide unique insight into how COVID-19 and the pandemic adaptation strategies employed by the education, healthcare, and sexuality education systems in Maine impacted youth sexual wellbeing, and what barriers and supports have persisted or arisen throughout the pandemic. A sample size of 8-10 participants was the recruitment goal for the individual interviews, as that sample size was determined most likely to reveal the diversity of participant experiences, but also allow for patterns in data to inform focus groups. It was also estimated that 6-8 participants out of 8-10 would agree to participate in the focus group discussions. The focus group size was desired to be large enough to include differing perspectives and create consensus among participant experiences, but small enough so that group work and group dynamics can be easily managed, and each participant would be able to contribute in-depth.

The four individuals who participated in the project reached out to me via email in the beginning of July. Once a participant had returned an electronic consent form, they were provided with a link to a demographic questionnaire via Google forms which gathered information on how the individual would want to participate – in-person or virtually – and the location they would like to meet at for an in-person meeting, as well as open ended self-identification questions on each youth's age, county in Maine where

they attended school, racial/ethnic identity, gender identity, sexual orientation, pronouns, if they identify as having a disability, and an open space at the end for any other information they thought was relevant. Collecting this information helped to inform how I would be connecting with and interacting with each participant, as well as the appropriate language to use to allow them to feel comfortable participating in the project. The identity related questions also informed the analysis process after the data collection was complete, as I was able to situate the experiences participants had described within the context of their identities and backgrounds and make distinctions and draw connections between participants with similar and differing identities and backgrounds. The gathering of this information aligned with the research objectives, as the theoretical framework and methodology make clear that studying sexual wellbeing accurately requires attention to the ways in which identity and intersectionality impact one's access to and relationship with sexual wellbeing. Both theories assert that sex and reproduction cannot be analyzed while ignoring identity, and that interventions that fail to consider the social contexts in which experiences of sex and reproduction take place are incomplete.

There was one potential participant who reached out wanting to be involved, but acknowledged that they were 17 years old, and therefore did not meet the age criterion. Because of limitations within the ethics clearance I received for my project related to the involvement of minors in my research, I was not able to include this participant in my research. Another participant did not reveal to me until the start of their interview that they also did not meet the age criterion as they were 24 years old at the time of data collection and were afraid that they would not be included. Because the number of participants remained well under the target number I had originally set, the relative closeness in age this participant had to the other participants, and this participant's desire to be included in the project and engage in these discussions, I decided to include them in the full process of the study. The ages of the participants were 18, 19, 20, and 24. One had heard of the study through Instagram, and the rest had learned of the opportunity to participate from their connections at youth-serving community organizations, who received the recruitment poster from Maine Family Planning and sent it along to them.

The impact of the recruitment methods used can be seen throughout the project, as each participant indicated the large roles that youth-serving community organizations had on their sexual wellbeing. The success of the methods is also apparent, as each participant expressed immediately to me that they feel comfortable talking about sexuality and were able to share deeply intimate critical analyses of their experiences of sexuality and wellbeing. They talked about how they had developed this comfortability because of learning, conversations, trainings, and work they had engaged in, both on their own and with the help of programming by these community organizations towards practicing sexual wellbeing and accruing sexual health knowledge and expertise. All went on to describe how this learning and comfortability was something they had found primarily outside of - or after - high school, with the help of community organizations. The recruitment of individuals who would be comfortable and familiar with discussing topics related to sexuality in-depth was deliberate. Each participant readily engaged in discussions with me about sexual wellbeing in a way that made it clear this is something of high importance and relevance to each of them in their daily lives and their future goals.

Because of the small group size, the three participants who were able to attend the online focus group sessions were all able to offer in-depth contributions to each discussion and began to feel familiar and comfortable with one another within the span of the three sessions. In reflection, a sample size of 8-10 participants, with the detail and depth of the testimony I was able to gather, would have been too much data to analyze for this thesis. The smaller sample size, therefore, allowed for each participant's narrative to be analyzed individually and collectively. Individual narratives laid out chronologically through a participant's story how each conceptualized sexual wellbeing, and then encountered and overcame barriers to practicing sexual wellbeing through accessing specific supports. When viewed collectively, narratives merged around themes that each participant had brought up independently and then were able to come together to discuss as a group. I found that participants' experiences weren't overly similar but offered a wide range of experiences and voices from those who are not usually represented in discussions of sexuality. I also did not find it difficult to synthesize participants' stories into a collective narrative, as despite the wide variance in participants' life experiences, their thoughts and ideas converged on similar

conceptions of sexual wellbeing, and concurrence on the impacts of the different factors each described as contributing to - and detracting from - their sexual wellbeing.

Interview and Focus Group Guides and Reflections

Each interview was semi-structured around the following guide:

Introduction: 10 Min

1. I introduce myself to the participant and allow them to introduce themselves to me in a casual manner. I introduce the project to them, explaining that this interview will ask them their initial, unpolished thoughts on the research questions with the goal of uncovering existing perspectives on youth sexual wellbeing. I go over the participant's signed consent form and the protocols of the interview, including confidentiality, participants' ability to pass or withdraw at any point, and offer a list of mental health and sexual health and safety resources to the participant.

Questions: 60 Min

In each interview, participants will be asked the following questions:

1. What does wellbeing mean to you? Is sexuality a part of that?
2. If I say "sexual wellbeing" what do you think of? Is it important to you?
3. Reflecting on experiences of sexual development (your own, your friends, stories you heard, etc.), were there key factors that positively or negatively affected sexual wellbeing?
4. Do you find that any aspect of your identity or community impacts your ability to access sexual wellbeing?
5. What is one thing you wish people knew about sexuality, sexual health, and/or sexual wellbeing?
6. In what settings and with whom do you feel the most comfortable talking about sexuality/sexual health/sex? What makes you feel comfortable, welcomed, or empowered?

7. Would you be willing to talk about these topics we have discussed today in a focus group with 8-10 other 18–22-year-olds from Maine? What might help you to feel welcome, safe, and comfortable in that setting?
8. What topics did we talk about today that you'd like to discuss in a focus group setting? Is there anything we did not get to talk about today that you'd like to discuss in a focus group setting?
9. Do you have any questions for me about the project or anything else?

Debrief: 10 Min

In wrapping up I discussed the participants' wishes for further participation. I did my best to ensure that the participant would be able to access the focus group discussions if they wished to. All participants expressed desire to participate in the focus group discussions, and

and I asked them to reflect on what they would like to get out of their involvement in the research project, and their goals of involvement, whether they are personal goals or involve communication with their broader community.

The focus groups included a series of 3 online sessions with the same group of youth throughout the month of August 2023. Having multiple shorter focus group meetings rather than one longer session better accommodated each participants' busy schedule. It also allowed participants more time to reflect on the lines of inquiry and build rapport with one another in a group setting through repeated meetings where participants can become more comfortable with one another. Participants were also given simple reflective activities to be completed on their own time in between meetings to allow for more in-depth, private reflection, but none completed these asynchronous activities, likely because of a lack of time, as each mentioned several other activities or events going on in their lives during the time of the focus group sessions. The focus groups deviated significantly from the initial guide I adapted from the GEM Tool. I discussed the direction of the focus groups with Lynette Johnson, my contact at Maine Family Planning, and we found that it would be repetitive and diminutive to follow the same lines of inquiry of the interviews, given the depth of the contributions from each participant in the interviews in response to the

same questions. I wanted to honor the contributions already made by participants in their interviews and give us space to collaboratively build upon what they had already expressed. I also wanted to include the suggestions of participants during interviews on what they wanted to discuss with other participants. These topics included:

-The sex education experiences of other participants

-How other participants learned about and practice sexual wellbeing

-What makes a safe space comfortable

The results of the meetings went as follows:

Meeting 1:

1. Intro to the Project: (5 minutes) I re-introduced participants to the project, myself, and my role as a researcher, and their role as participants.
2. Consent: (5 minutes) I went over the free, prior, informed consent protocol we had in place through the duration of the participants' involvement in the study. I emphasized that participants would direct their own involvement and participation, and can opt out of an activity, take a break, or withdraw completely at any time.
3. Icebreaker, Group Agreements, Goal Setting: (50 minutes) The first session included with group building activities, including an ice breaker and the collaborative creation of group agreements, to initiate participants with myself and one another, as well as the participation process. "What group agreements should be in place for the duration of our time together?" was the first reflective question we answered as a group. We also discussed the goals of the research project, including my goals as an individual, the goals of the project itself, and the goals that participants may want to achieve from their involvement. I had written out some group agreements prior to meeting with the participants, based upon what they described in their interviews as characteristics of a space in which they feel safe and comfortable talking about sexual wellbeing. I asked them for any contributions. Participants were mostly silent throughout the introduction,

likely getting a feel for the group space and the other participants who they were meeting for the first time. The ice breaker activity we did was an interactive timeline through Zoom whiteboard which each participant was to fill in to describe the events, connections, emotions, thoughts, or experiences which led them to be involved in this study, similar to the introduction I had given them all at the start of their interviews. One participant had joined the session on a mobile device rather than a desktop computer, and wasn't able to easily access the Zoom whiteboard, so they wrote their timeline down using pen and paper. Each participant then presented their story as to how and why they joined this study.

4. Sharing Factors of Sexual Wellbeing from Individual Interviews: (approximately 10 minutes) In the first focus group I presented a visual representation of the key factors of sexual wellbeing each individual had emphasized independently and to different degrees in their interviews. These made up the sexual wellbeing categories, akin to the categories of empowerment which participants create in the GEM Tool model. The factors of sexual wellbeing were relation to self, relation to others, access to resources, access to education, and access to safe spaces. I presented this in the form of a diagram I had made using Zoom whiteboard.
5. Discussion of Factors of Sexual Wellbeing from Individual Interviews: (approximately 30 minutes) I initially asked participants what they thought about the diagram as a whole, then opened a larger discussion about each of the factors I had listed, and how the diagram also had spaces for each of these categories on the individual, community, and society levels. The idea of the diagram was that participants would be able to fill in the spaces under each factor, describing what that aspect of sexual wellbeing may look like on the individual, community, and society levels in their lives. However, because one participant couldn't access the whiteboard, and I was also encountering technical difficulties in being able to share the whiteboard on my screen or having it load at all, this portion of the discussion did not occur.
6. Closing the Meeting (20 minutes): We decided, as a group, to end the session early. I suggested that we do this as participants had been hesitant to speak up and were just getting acclimated to

the setting and familiar with one another. I recognized it would take time to get to a space where participation would be accessible and comfortable for all of them. Pushing through with limited accessibility or discussions I had not yet prepared would be a disservice and went against the principles upon which I had built this project, an example of buying into the Western-centric values of product and outcomes over adequate attention to the process. Instead, we closed the meeting by discussing our availability to meet again and ensuring each participant would be able to attend the next meeting on a computer rather than mobile device. I sent them the anonymous Google form exit poll I created asking questions such as "This session could be improved by….", and "I would be more comfortable participating if…". Only one participant answered the exit poll with a note indicating that they enjoyed hearing others' ideas, felt that they would be more comfortable participating in follow-up meetings now that they had been introduced to the other participants, and expressed that they were looking forward to having more time to talk.

Meeting 2:

1. Participant Check-in and Group Agreement Reiteration (25 minutes): Participants were reacquainted with one another with another icebreaker activity and reviewed group agreements to adapt. Rather than having a structured introductory icebreaker, I was able to open a more casual conversation because of the small number of participants. I simply had each participant describe how they were feeling that day and what they had been up to in the time since our last session. I reemphasized consent protocols, confidentiality agreements, and resources available.
2. Reflection and Presentation of Thoughts (approximately 20 minutes): I decided to use Google Jamboard over Zoom whiteboards as a more accessible and easily navigable discussion space. I had created a Jamboard which featured the questions: "When/where/with who did you last talk about or learn about sexual wellbeing or sexuality?" and "What makes a safe space feel comfortable to talk about sexual wellbeing?" then pages for each of the sexual wellbeing factors named above which were separated into 3 parts: individual, community, and society. I introduced the questions and then gave participants 5 minutes to reflect on each question on the first slide.

Each participant was able to access Jamboard and had no difficulties writing and adding sticky notes under each category during this time. Each participant then presented and expanded on what they wrote, fueling a group discussion on safe people and safe spaces and what makes them "safe."

3. Revisiting Sexual Wellbeing Categories from Last Meeting (60 minutes): We then went to the sexual wellbeing category of access to safe spaces, and given reflection time, each participant wrote what this looked like for them as an individual, in their community, and in society. Each participant was then given time to present and share their thoughts. By this time, participants began to participate readily, share personal experiences, and connect with and relate to one another's experiences, building a group consensus. Access to safe spaces was the only category of sexual wellbeing we had time to address during this meeting. I wanted to give space and time to each participant to share their thoughts and feelings, and not feel like they were being rushed or like others had more time. Therefore, I made a point to not switch topics of discussion until it was abundantly clear participants did not have any other thoughts to share on that particular subject. In addition, one participant has a stutter, and benefited from additional time to share their ideas. Rushing through topics or emphasizing that we did not have much time might have discouraged this participant from participating in their full capacity, as they mentioned throughout their interview that they had frequently not been listened to throughout their life, had been shot down when they tried to speak, or that nobody had the patience to sit down and talk with them or answer their questions. Other participants also emphasized that a safe space was one where there was adequate space for sharing and listening to one another. Thus, this lack of urgency on my part as the facilitator of the discussion was deliberate, and again, aligned with the principles guiding the methodology I was using, in which I did my best to place the quality and depth of participants' contributions above the number of questions we were able to address.
4. Closing the Meeting (20 minutes): In closing the meeting, we discussed what each of us was going to be doing in the weeks ahead, and our availability for the next meeting. I informed the

participants that the next meeting was our last one, where I would ask any final questions I had for them, and we would revisit the topics we had talked about, to ensure that I would be able to accurately represent their voices and was not missing anything they thought would be important to include in my data.

Meeting 3:

1. Final Meeting - Wrapping up Loose Ends (60 Minutes): As this meeting took place during the last week of August, participants were beginning to become too busy to continue their involvement in this project. As a result, we only had a strict one-hour period for the final meeting. After re-emphasizing consent protocols, I launched into the questions I had set up on the Google Jamboard. Two topics had been mentioned by my contacts at Maine Family Planning as important inquiries: the role of the internet and the impact of COVID-19 on sexual wellbeing. These topics were also mentioned in the literature as areas of interest in terms of youth sexual health and education. Interestingly, no participants mentioned COVID-19 in their interviews. Two participants had mentioned the internet during their interviews but had not gone into detail on its impact on their sexual wellbeing. Reflecting this, my final questions were: "What impact did COVID-19 have on your sexual wellbeing?" and "What impact did the internet have on your sexual wellbeing?" Participants were given time to reflect on both questions, write their sticky notes, and then present their thoughts on them in turn. Once this discussion was finished, the hour was essentially up.

2. Wrapping up the Final Meeting (5 minutes): I asked participants to fill out an exit poll I would be sending them to debrief on the research process as a group and share any final thoughts, reflections, or feelings that arose throughout the process. I asked participants if they had any final thoughts, but because of other commitments, there was not adequate space for this question to be answered. Participants did express wishing we could keep having discussions together on sexual wellbeing, although only one said that they would potentially have the time and space to participate in the fall, as the others were beginning new semesters at their universities. This participant expressed that they "did not want to lose" this space. I assured them that we would reconnect, as I did not have the opportunity to go through a summary of our

discussions and confirm the main themes of the research with the participants or discuss the role they wanted to have in the dissemination of results. I am planning to reconnect with the participants following the submission of this thesis at which time I will gauge their interest in participating in these discussions and presenting the knowledge we gained from this research, knowing it is just as much their knowledge as mine.

Data Analysis

With the consent of each participant, all the meetings, both online and in-person interviews and focus groups were audio recorded. I began the analysis process of the interviews before the focus group sessions took place. I listened to and transcribed the interviews using the transcription software Descript. Through a combined process of deductive and inductive coding, I went through each transcript and highlighted testimony according to which major research question it spoke to: As participants understand it - what is sexual wellbeing? What are the barriers to sexual wellbeing? What are the supports to sexual wellbeing? I made physical notes on each of the audio recordings on a large white board, adding as I went through each interview, emphasizing topics which came up repeatedly, and connecting related themes with lines drawn between them. Through this documentation and visualization process, I was able to draw out the pieces of participants narratives which answered the major research questions.

I presented my findings to the participants in the first focus group session, particularly, the collective summation of the foundational factors of sexual wellbeing as it was conceptualized by each participant. These initial categories of sexual wellbeing: Relation to self, relation to others, access to resources, access to education, and access to safe spaces became the thematic categories through which I deductively coded interview data to determine the barriers and supports within each of these factors. In the focus group sessions, I asked participants to build consensus upon and add detail to these categories. With participants' consent, all three of the focus group sessions were video and audio recorded. Digital visualizations of data were also generated during the focus groups and revisited during data analysis.

I used Microsoft Word to transcribe the focus group session recordings, as I had run out of free transcription minutes on Descript. I listened to, transcribed, and went through the same coding process of organizing the qualitative data of each session thematically per question, going through a process of inductive coding on what topics came up in response to each question, then deductive coding based upon the aforementioned categories. The results provided an expansive and illustrative qualitative data set answering the question: What contributes to youth sexual wellbeing? For the specific participants and context in which I am researching. The findings of the data have been situated in the existing literature on youth sexual wellbeing in the results and analysis section of the paper directly following this section. The implications for both local interventions and academic scholarship relating to sexual wellbeing are discussed in the conclusion, along with my recommendations for both community action and further academic research.

Ethics and Positionality Statement

My research involved human subjects as well as the discussion of potentially sensitive topics, related to which participants have potentially experienced adverse life events. While it was made known to participants in the recruitment process that they must be willing to reflect on experiences and perspectives of sexuality, sexual development, and sexual wellbeing, special attention was also paid to confidentiality, anonymity in public information, and free, prior, and informed consent throughout the research process. Further, for the safety of participants, community resources related to sexual violence, gender-based violence, mental health, and support for LGBTQ+ individuals were provided and made readily available to all participants. Within the recruitment process, special attention was paid to equity, diversity, inclusion, and accessibility, ensuring that advertising was widespread and directed through channels specifically designed to reach communities who are underrepresented and underserved in Maine and sexuality education and support, such as immigrants and refugees, young people with disabilities, and youth in foster care. A point of contact was included in recruitment materials where applicants or

potential applicants could reach out to me to make any accessibility needs known, and accessibility needs were also addressed throughout the process as they came up, for instance, hosting interviews and focus groups online or in-person, delaying activities until all participants had adequate materials, and enabling captioning in online meetings.

The success of this research was contingent on participants feeling included, respected, welcome, comfortable, and listened to. A large driver of my passion in this subject area is my own lived experiences of sexual wellbeing. As an AFAB (assigned female at birth), queer, and nonbinary adolescent, growing up and attending school in Maine, I was denied the space to express frustration, shame, discomfort, agency, resourcefulness, and power in relation to my own sexual wellbeing. However, as I returned to Maine to conduct this research, my positionality had changed. My role as a researcher in academia and as a facilitator is imbued with power and privilege. To be successful, it was necessary for me to examine the way this positionality impacted my involvement in the focus group discussions and see where this innate power had the potential to create a hierarchy of the legitimacy of ideas within the group, with mine, as a white, English-speaking settler conducting scholarly research, taking precedence. Because the nature of the project was to explore lived experiences and realities that may not align with my own, my role was one of stepping back and allowing participants to guide the direction of the conversations, exerting minimal authority on the subjects discussed, and letting participants speak for themselves.

To ensure that the proper ethics protocols were adhered to, and to maximize the comfort, safety, and positive experience of participants, I submitted an application to the Ethics Review Board at the University of Ottawa and received approval for this project.

Chapter 4: Results, Discussion, and Analysis

One of the major research questions this project set out to contribute to is “what is sexual wellbeing?” This project explored how four young people in Maine conceptualize sexual wellbeing in their own lives, including how they define it, how they practice it, and what it looks like for them. The

other two lines of inquiry explored barriers and supports related to sexual wellbeing experienced by youth in Maine. Beginning with individual interviews followed by focus group discussions with three out of four participants, narratives emerged surrounding these topics. Despite growing up not far from one another within in the same state, each participant pieced together a unique picture of their sexual wellbeing, the barriers they encountered, and the supports they were able to access, rooted in the contexts from which they came. Participants identified shared and differing experiences in the focus group setting, as individual narratives merged through collective sharing and storytelling. Throughout the initial interview process, independent testimonies mirrored one another on what sexual wellbeing is, and how it is practiced by each participant. Participants demonstrated a notable ability to critically analyze the roots of the barriers they faced in practicing sexual wellbeing, as well as an insightful grasp of what tools, resources, and supports enabled them to overcome these barriers and to effectively practice sexual wellbeing as they understand it.

In this chapter, I first break down the collective narrative that emerged from participants' testimonies surrounding how they understand, conceptualize, and practice sexual wellbeing. I situate the participants' definitions surrounding sexual wellbeing within the literature on the same concept highlighting similarities and divergences. I then move on to their lived experiences of barriers, and what they described as the major challenges in practicing sexual wellbeing, and finally, I document the specific supports these participants identified in their lives as helping them along the way, in overcoming barriers and enabling them to practice sexual wellbeing. I situate the major barriers and supports identified by participants within the theoretical framework and compare my findings with relevant literature, identifying areas where the results of this study are reinforcing, challenging, and unique within the literature on sexual and reproductive justice, sexuality education in the U.S., and sexual wellbeing as a concept.

Throughout this section, I employ the use of long quotes from participants. Due to the nature and the goals of the research, as well as the small sample size, the data takes the form of deeply intimate, powerful, and personal stories and anecdotes participants shared from their own lives as we discussed the

research questions. In alignment with the methodologies of RJ theory, and the Native Feminist Theories of Million and Tuhiwai Smith, I felt that including these stories would be the most effective and genuine way to showcase the data I gathered from the participants and allow the discussion of results to center participants' rather than my own voice. Tuhiwai Smith writes about storytelling as "a useful and culturally appropriate way of representing the 'diversities of truth' within which the storyteller rather than the researcher retains control" (p. 166). This narrative style also allows the reader to hear the lived experience of the participants in their own words, in their own voices, as they told it. A narrative style gives the reader a taste of the knowledge imparted in the stories told by these young people, and gives the reader practice at listening, believing, and understanding the lived experiences of young people as legitimate, scholarly perspectives on real issues that they face.

At times, participants' narratives addressed subjects beyond what would typically be considered part of sexual health. This is deliberate. When I chose sexual wellbeing as the conceptual center point of this study, I did so in alignment with my research methodologies, to disrupt notions of sexual health rooted in oppressive hierarchies that fail to include the diversity, nuances, and complexities of human experiences and to challenge assumptions surrounding what is important or not important when considering health and wellbeing. As Mitchell et al. (2021) noted, "the conflation of sexual wellbeing and sexual health obscures the diversity of experiences—not clearly addressed in definitions of sexual health—that people identify as relevant to their broader wellbeing" (p. 608). Thus, each of the stories told by these participants is important, and, because they chose to talk about them during our discussion on sexual wellbeing, they are about sexual wellbeing. Before each interview, as I was introducing myself and my project to each participant, I made it clear that what I was looking for was nothing in particular, that there were no right or wrong answers to the questions, and that they didn't need any knowledge aside from that they had as experts of their own lived experiences. This is why, in this section, this is the expertise I am centering.

Overview of Findings

The findings are divided into three major sections: 1. Defining Sexual Wellbeing, 2. Barriers to Sexual Wellbeing, and 3. Supports of Sexual Wellbeing. Section 1 has 5 subsections: Defining sexual wellbeing, and one subsection for each component of sexual wellbeing – access to resources, interpersonal support, access to education, and access to safe spaces. Section 2, on barriers, has 4 subsections: Experiencing violations of physical and psychological safety, security, and autonomy; societal silence, shame, and stigma surrounding youth sexuality; receiving inadequate, incomplete, or inaccurate information on sexuality; and having systemically unequal access to resources, support, education, and safe spaces. Section 3, on supports, has 4 subsections: Community organizations as hubs of sexual wellbeing; effective, accessible, accepting spaces of learning; formal and informal peer networks; and openness, care, acceptance, and encouragement from adults. Most of these subsections cover a broad range of topics and have headings that denote the main ideas within them. My analysis of the findings and the application of relevant literature to the research results can be found throughout each section of this chapter. I found this to be an effective way of presenting both findings and discussion as each section builds upon the previous sections, forming a cumulative illustration of the contributions of the findings to the relevant literature. In my presentation of the findings, I have assigned each participant a pseudonym. I recognize that names are imbued with power and have a role in shaping perceived identity, so I have attempted to choose pseudonyms which best reflect the identity of each participant as they presented it to me. In any public presentation of the research results, I may choose to forgo denotation of quote or ideas to specific participants to protect their identities and refer to them using neutral "they" pronouns. However, for this version of the paper, I will use the proper pronouns of each participant, given the importance of gender identity in the analysis of the power structures which influence sexual wellbeing. The participants will be known as Gale (he/him), Sam (any pronouns), Gabriela (she/her), and Helena (she/her).

Section 1: Defining Sexual Wellbeing

Sexual wellbeing, as these young people understand it, is a multi-faceted and diverse, lifelong experience of exploring, knowing, and accepting yourself, including your identity, your body, and your sexuality. When I refer to sexual wellbeing from now on throughout this paper, this is the definition I will be referring to, unless otherwise specified. According to the young people involved in this study, sexual wellbeing is not a state you can achieve, it's not one singular feeling of wellness, but a collection of emotions, connections, life events, and learning processes related to one's sexuality (and all that it encompasses, i.e. body, identity, boundaries, pleasure, wants and needs, health and safety) which come together to create the experience of sexual wellbeing. Helena sums it up well: *"it is important to know who you are and... there is no shame."*

For the participants, practicing sexual wellbeing means learning how to take care of yourself in all aspects. In their words, they described how practicing sexual wellbeing requires you to find out what sexuality and wellbeing mean for you, and access the support, education, resources, and the spaces to be able to enact it. As Gabriela expressed, *"It kind of encompasses both physical and mental health and …it kind of means consistently trying to cultivate and take care of yourself and all parts of that, and kind of being accepting of the process and… journey that that takes you on."* All participants made it clear that this is by no means a process you undertake by yourself or in a vacuum. Sexual wellbeing is extremely intertwined with one's mental, physical, and emotional health, safety, and wellbeing, as well as the environment and the communities they are a part of. Sam remarked in a focus group meeting how *"sexual health is not just about individuals and their interactions, it's also about, you know, trends in society in terms of STIs or acceptance for different sexualities, or our ability as a society to talk about things openly, or if there's a lot of taboo."* Sam's testimony mirrored the perspective Gabriela shared during her interview in describing how societal norms and taboo impact sexual wellbeing: *"Sexuality plays such an important part in how we perceive ourselves and how other people ...perceive us. …especially where we live in an environment where it can be really taboo, especially for young people, it's really hard to deal with and can kind of create an environment of shame.... learning to tackle that and kind of accept yourself as you are... can be really hard, but is such an important part of wellbeing. And it just kind of falls under*

that umbrella of being able to take care of yourself." The way that participants described sexual wellbeing made it clear that it is a relational part of our relationships with ourselves, wherein it exists within each of us to be understood by us, but it also concerns how others perceive us and how we interact with others. It cannot be examined without these contexts or understood on its own as a static singularity. It's a living, growing, changing, unique thing in each of us.

Something emphasized by participants was that sexual wellbeing can be understood as a relationship with oneself. As mentioned above, sexual wellbeing, as understood by the young people involved in this project, has no specific meaning on its own. These young people found that sexual wellbeing is deeply personal and individual, and is a concept that is ascribed meaning, not only through gaining knowledge on the subject of sexuality, but through its application to oneself. Participants were quick to point out how this piece is missing in most sexuality education. As Gabriela said, *"It's a process that we really need to think through and... have to think about what it means for us… it's such a personal thing, and at the end of the day, we can go through... all these curriculums and learn all this stuff about it, but if you don't kind of think about it yourself and kind of tackle what it means to you... it's not going to mean as much."*

Participants pointed out that sexual wellbeing requires a high level of self-awareness and self-knowledge developed and maintained over time. Participants described practicing wellbeing as involving taking time to *"just try to sit and think,"* and *"being in tune with your body and your wants and needs,"* in order to be able to take care of yourself. For the participants, this process of getting to know oneself in terms of sexual wellbeing was closely related to their identity, as Sam expressed, *"For me, my queerness and my understanding of sexual health are one and the same."*

Authors such as Mitchell et al. (2021), and Lorimer et al. (2019) in their analyses of multiple definitions of sexual wellbeing also concluded that a large part of sexual wellbeing is an individual's perception of self, related to their sexuality and sexual experiences. Mitchell et al.'s (2021) definition of sexual wellbeing included factors such as sexual self-esteem, resilience, and forgiveness related to sexual experiences. These factors can be compared to those which came up in my research, of self-exploration,

understanding, and self-acceptance. Like the participants, Mitchell et al. (2021) considered sexual wellbeing as a set of mental and emotional factors, respect and recognition from others, and practices related to personal physical safety and security, such as self-determination and ease of communication. However, the participants in my study conceptualized sexual wellbeing as more process than outcome oriented. Whereas Mitchell et al. (2021) viewed practicing sexual wellbeing as the achievement of these positive sexual self-concepts and practices, the participants in my study viewed it as a continuous process of learning to care for oneself in relation to these areas. Unlike the participants, Mitchell et al. also made clear distinctions between sexual health, sexual pleasure, sexual justice, and sexual wellbeing, and therefore did not specifically include factors of broader physical health, access to resources and knowledge, or social/cultural or environmental factors within their definition of sexual wellbeing. These are factors that the participants in my study named as foundational to sexual wellbeing, indicating that they tended to view sexual health, pleasure, and justice as falling under the umbrella of sexual wellbeing, or that the divisions between these concepts are more blurred for them.

In this way, participants described sexual wellbeing in a similar way to Lorimer et al. (2019), in that it includes self-perception of sexuality and sexual functioning, and being able to access what one needs to function. Like the participants, Lorimer et al. also viewed this as including interpersonal and socio-cultural factors which impact sexual functioning. Mirroring my own conclusions from participants testimony, Lorimer et al. (2019) described the "importance of conceptualizing sexual wellbeing as individually experienced but socially and structurally influenced" (p. 849). Thus, the definition of sexual wellbeing given in this study, and the participants descriptions of what practicing sexual wellbeing means to them allows us to find an important middle ground between these two summative perspectives of sexual wellbeing in the literature. Sexual wellbeing, as defined by this study includes important emotional aspects which go beyond "sexual functioning," but also considers external and structural impacts, and emphasizes the agency of the individual in a way that's not included in the literature, centering the role of the self in enacting processes of self-care contributing to the practice of sexual wellbeing.

In Lorimer et al. (2019)'s review of 162 papers on sexual wellbeing, only 10 included a definition of sexual wellbeing. This trend in the literature renders my study unique within papers which refer to "sexual wellbeing" without interrogating what, exactly, the term is referring to. Additionally, of those 10 which included a definition of sexual wellbeing, only 3 referred to a holistic understanding of the concept which included multiple domains, such as physical, emotional, and social aspects of one's self-perception. Further, simply because of the range and importance of topics that are discussed at length in the data, my study includes themes that were glaring omissions in the literature on sexual wellbeing brought to light by Lorimer et al.'s review. The authors indicate that of the 162 papers, only 10 explicitly included LGBT experiences, and only 11 papers discussed socio-cultural influences on sexual wellbeing. The authors located gaps in the literature surrounding what they considered to be several key influences of sexual wellbeing: sexual health literacy, peer influences/norms, poverty and access to basic needs, gender-based violence and childhood abuse beyond intimate partner violence, and systems of oppression, such as gender inequality. My paper includes discussions of all of these topics and found them integral to understanding sexual wellbeing and barriers and supports relating to it. Lorimer et al. (2019) also found that few studies employed qualitative methods, few looked into sexual wellbeing over time, and few examined the concurrence of individual and socio-cultural or structural influences on sexual wellbeing. My study, by design, provides a model for addressing these gaps. By using methods focusing exclusively on qualitative data, and by not limiting my lines of inquiry to one specific factor in sexual wellbeing, I deliberately centered individuals' lived experiences of sexual wellbeing throughout their lives in understanding its definition, which proved to be an implicitly holistic and expansive lens. Because of this, participants were able to bring to light other aspects of sexual wellbeing not considered in the literature, such as the importance of interpersonal relationships which aren't necessarily romantic or sexual partnerships in understanding oneself and one's sexuality, the necessity of knowledge and education in building one's self-relationship, and the fundamental need of having a safe space to be.

As I was going through this analysis, I deliberated on whether these elements are supports for sexual wellbeing, or if they are part of sexual wellbeing itself. In Lorimer et al. (2019)'s discussion of

sexual wellbeing in relation to the capabilities one has to achieve sexual wellbeing, the authors also point out this same conundrum, but offer a term which eases the tension within it. They point out how certain influences and constraints on sexual wellbeing can be read as "conversion factors" or those factors which blur the lines between influences and attributes of sexual wellbeing and could be considered as both (p. 848). In my analysis of the findings, I was careful in teasing out of participants' language which of these conversion factors they considered integral to sexual wellbeing (attributes), and which they mentioned as factors which supported their practice of sexual wellbeing (influences). I found that participants did understand attributes of sexual wellbeing as a combination of what could be considered conversion factors. For these young people, sexual wellbeing was found to be comprised of interrelated but distinct factors: interpersonal relationships, access to resources, access to education, and access to safe spaces.

The ways in which participants described these factors made it clear that to them, they weren't factors which influenced their sexual wellbeing, but part of sexual wellbeing itself. As Gale aptly noted: *"It's kind of hard when you don't have the resources or someone to talk to, or if you don't even know that's even a thing to be thinking about."* I found that when participants described influences and constraints on their sexual wellbeing, they were more specific in naming the resources, tools, or people in their lives that either made it easier or more difficult to access the attributes of sexual wellbeing. This allowed me to distinguish between the broader categories which comprise sexual wellbeing for the participants, and the barriers and supports that influenced participants' ability to practice sexual wellbeing within each of the categories. I will discuss each category in turn in the following sections, although there are many cases where they intertwine.

Access to Resources

Meeting the Basic Needs of Survival

The participants exhibited a wide range of experiences related to accessing the resources necessary for sexual wellbeing. One of the underlying necessities for practicing sexual wellbeing was

being able to meet one's basic needs. While this seems like a given, having access to the material requirements for survival is often missed as an input in sexual health or wellbeing, leaving out those who are most in need of support. This oversight is part of a neoliberal understanding of sexual health, within which health is something governed by individual decision-making, regardless of the material conditions that may restrict these decisions (Elliot, 2014). RJ as a theoretical framework centers understandings of sexual or reproductive wellbeing within "the relationship between health, health care, poverty, community empowerment, and the experiences of individuals... these perspectives demonstrate the limits of the marketplace concept of free, unimpeded individual 'choice'" (Ross and Solinger, 2017, p. 12). Gale had experienced homelessness sporadically throughout his teen years, and expressed that having access to basic needs, such as physical safety, housing, food, and clothing, was required for practicing sexual wellbeing. He highlighted how, *"being homeless is one of the bigger things... personally for me as a younger youth my sexual wellbeing was way off... so it's kind of hard to practice that in unsafe situations."* He described the difficulty he had in trying to understand his sexuality and identity while struggling with being able to meet his basic needs as a homeless youth: *"Coming out and then being homeless almost immediately after was really hard because then I couldn't… I was trying to figure myself out."*

Accessible Healthcare, including Sexual Healthcare, Gender Affirming care, and Mental Healthcare

Other vital resources for practicing sexual wellbeing mentioned by participants were healthcare, including sexual healthcare, mental healthcare, and gender affirming care. In the above quote, Ross and Solinger (2017) emphasize the role of overall health and access to healthcare in reproductive and sexual wellbeing. This idea was also mentioned repeatedly by participants, who considered being able to access healthcare when you need it to be integral to sexual wellbeing. To them, healthcare included sexual healthcare, including contraceptives, and safe sex tools, mental healthcare – as Gale and Helena both emphasized the importance of therapy - as well as gender affirming care, which was mentioned by Gale

who self-identified as trans. Helena discussed the interconnectedness of meeting her basic needs of safety, and accessing healthcare and mental healthcare, as she talked about struggling with her mental health, and struggling to be listened to as a person with a disability when she had to visit the emergency room: *"...not having a stable place, and going to the hospital, but then having no one believe you until you... try and take your own life... that shouldn't be the case."*

Other Vital Resources: The Internet

Participants mentioned the importance of other vital resources, such as a reliable internet connection. Gabriela in particular found the internet to be a necessary resource for understanding and accepting herself: *"The internet was such a big resource and just finding people who would talk about it openly and stuff and just kind of learning their experiences, how that kind of related with mine… kind of figuring out how I saw myself and then... looking towards people who felt similarly and just learning from them."* The lived experiences of TNB youth described by Haley et al. (2019) also reflect the same sentiment as this participant. The authors discuss how many youth "specifically sought online sources that included personal narratives and stories of other TNB people," and how this helped them to understand their own feelings, emotions, and identities (p. 1840). Both the literature and this participant relayed how for some, being able to access online resources and make virtual connections with or see the stories of others with similar identities and experiences was integral to practicing sexual wellbeing, in particular, for youth who do not have these resources or supports readily available to them in their communities. It was clear that having access to resources, although it meant different things to different participants according to the needs and experiences of each, was a necessary condition for being able to practice sexual wellbeing.

Interpersonal Support

Having Somebody to Talk To

Gale summed up sexual wellbeing as, *"Healthy relationships, healthy self,"* indicating the high importance of relational aspects of sexual wellbeing, in addition to internal senses of self, self-acceptance, and self-care. All participants alluded to the necessity of having *"somebody to talk to"* as a factor in learning how to practice the self-care of sexual wellbeing. This "somebody" was a different person in each of the participants' lives, but each referenced having at least one person they could go to for sexual health support or to have conversations on sexuality; somebody who would be able to help them *"talk through things,"* or practice the self-exploration, self-acceptance, and self-care of sexual wellbeing. For example, Sam emphasized the role of interpersonal relationships between sexual partners, as they expressed, *"I would say the biggest way to practice sexual wellbeing is… to have open conversations with your sexual partners... you know, making sure that you're both liking what's going on."* The literature notes that discussions of interpersonal relationships or "healthy relationships" in sexual health tend to focus mainly on romantic or sexual partners as points of communication or sources of support for sexual health and wellbeing. Further, these conversations tended to be limited to heterosexual or binary gendered relationships (Goldfarb and Lieberman, 2021; Lorimer et al., 2019). These conversations then omit the diversity of interpersonal relationships young people experience, with peers, parents, or others and the importance of these relationships to adolescents' ability to understand, accept, and advocate for themselves. For example, Helena mentioned that there was only one person she felt she could talk to about sexuality and sexual wellbeing, saying *"I talked to my family friend. That's about it… I just didn't feel comfortable talking about it with other people."* For some, vital interpersonal relationships were with a therapist, friends, family friends, partners, but no matter who it was in the participants' life that was able to provide support, the person was somebody who participants felt cared about them, who they felt would not judge them, who they felt would respect their privacy, and who they felt comfortable and safe speaking openly to.

Relationships which are Non-Judgmental, Confidential, Built on Mutual Trust, Respect, and Care

It was clear that the most vital interpersonal relationships to sexual wellbeing were those that participants perceived as having certain qualities, specifically, relationships where the other person is non-judgmental and will respect the participants' privacy. These were relationships wherein the participant feels they have mutual trust, respect, and are cared for. Gale mentioned the importance of confidentiality and trust, saying how, *"it was just nice knowing that you could talk to someone and it wouldn't get back to any of your other friends, so you wouldn't be judged."* Sam, Gabriela, and Helena found consensus during the focus group sessions, agreeing on similar qualities which were important in identifying a person who could offer interpersonal support. They described an element of caring: *"I see in common... someone who cares,"* as well as mutual trust: *"For a lot of us, we were kind of having these conversations with people we trust and who trust us... that's kind of what [Helena] was saying… like with people who understand you too... having people you just feel comfortable with."*

Closeness, Intimacy, and Boundaries in Relationships

Participants pointed out the importance of boundaries in these relationships as well and asserted that being able to set them and talk about them openly is an integral piece of having that relationship. Gabriela pointed out the comfortability with boundaries that accompanies knowing somebody on a deeper level, wherein the higher level of intimacy you have with a partner, friend, or family member, the more implicitly understood these boundaries become. She said, *"If you're really comfortable with the person or if you've known them for a long time or you've talked about a lot of stuff... [you have] this mutual understanding of what you are comfortable with."* Participants made it clear that having a person they could talk to in this way was about more than that persons' non-judgmental attitude or respect of their boundaries, but also their relationship with that person and its continuity over time, and the level of mutual respect, understanding, trust, and intimacy between them. Part of it was the ability of participants

to be able to show their authentic self to that person, to know them and be known by them, and to be received with acceptance.

Participants described these relationships as integral to their ability to understand themselves and their overall sexual wellbeing, intertwining with other categories. Some participants described not having access to interpersonal relationships like this when they needed them but went on to illustrate how finding a safe and accepting space and community support was often a way to identify or find somebody whom they could feel close with, or comfortable enough around, to gain interpersonal support. For other participants, their close interpersonal relationships, with their family, friends, or partner created safe spaces for them wherever they were with these people. Interpersonal support was also a significant factor in participants' access to knowledge and ability to process sexual health information. As Gabriela described, *"I learned and felt the most comfortable when I was just talking with people who were closest to me."* Healthy and intimate interpersonal relationships and having access to interpersonal support was consistently identified by participants throughout our conversations as integral to each of their sexual wellbeing.

Access to Education and Information

What do Sex and Sexuality Mean?

Participants made it clear that practicing sexual wellbeing required learning, information, and knowledge, beginning with the awareness that it's *"even a thing to be thinking about."* In this study, participants made clear distinctions between the sex education they may or may not have received in school and the education, learning, and knowledge that has contributed to their sexual wellbeing. This contrast will be laid out in more detail in the following sections on barriers and supports. That said, I feel that it's important to make it clear that the education that participants are referring to in these quotes is referring to what they learned when they were able to access spaces of learning where they felt safe,

comfortable, accepted, and open to learning, and received information that was relevant to their experiences and identities. Having access to information was also vital to participants in understanding what sex and sexuality *mean*, and in particular, what they mean for them.

Helena, who identified as heterosexual, and Sam who identified as lesbian both discussed how they had a lack of knowledge of what sex is in high school, let alone an understanding of their boundaries, wants and needs, or physical health and safety related to engaging in sex. Helena described how she first chose to take a sexuality education course to fill her own knowledge gaps, once she was out of high school, saying *"I had a healthy relationships class, and... it talked about condoms, sex ed, masturbation, and the types of transmitted diseases… At the time, I didn't really have a good understanding of sex and of condoms so I took the class."* Sam described feeling confused and anxious about sex because of the lack of information: *"I had all these anxieties and misconceptions about what queer sex was. I remember being in high school, being so anxious that I'm gonna lose my virginity and not know it because I don't know what sex means for me as a lesbian."*

The Importance of Knowledge in Reproductive and Sexual Autonomy and Self-Determination

Participants also noted how having information allowed them to practice sexual wellbeing by allowing them the space to make decisions for themselves and enabling them and empowering them to access resources that they did not know of before. Two participants described being given birth control as young children by their parents, before they even knew the purpose of contraception. This infringement on their bodily autonomy and reproductive and sexual health decision-making was part of the abuse they experienced in the homes where they grew up, and a product of their parents' attitudes towards their sexuality. It also could be in part because of attitudes related to their identities, as both of these participants also identified as having a disability. The ways in which these participants' home environments were a barrier to their sexual wellbeing will be discussed further in the section on barriers.

Despite lacking autonomy over their reproductive and sexual health care, even while their guardians deemed it necessary to be on birth control, each was able to find empowerment and self-determination through gaining knowledge on sexuality, and what it means to them. As Helena described, *"...I already knew about birth control... because I used to be on the pill. But I didn't really know the… side effects and the reason why I was on the pill. So when I found out, I'm like, oh, wow, this is very interesting. That's how I chose the implant."* Both participants learned how they could use knowledge, such as on different birth control options, to claim agency over the way they viewed themselves and their sexuality in a way they had not been allowed to, or able to, before. Gale summed this up well when he described his experience of *"learning about everything… and just understanding myself more… knowledge is power."*

The Importance of Information for LGBTQ+ Sexual Wellbeing

Having access to information was a significant piece of wellbeing for queer identifying participants. Having education on LGBTQ+ sexuality was vital for them in defining sex for themselves, exploring their identities, and understanding their own sexuality. As one participant described, having this education is often accompanied by the realization of *"that's an option?"* Participants who identified as queer described the necessity of receiving knowledge on LGBTQ+ identities, sexualities, and the experiences of others who are LGBTQ+ as they explored their own identities, emotions, feelings of attraction, and ability to relate to their peers or not. Many described struggling with accepting their feelings, and themselves as a result, as they began to recognize the way they felt was different from the norms they saw around them. Gabriela describes this feeling as one of shame, saying, *"If you don't feel the same as someone… it creates a sense of shame. Like, why don't I feel the way that other people do about this thing? And it makes it harder to deal with… you feel like what I'm feeling is wrong, it's not right… It adds another step... you have to learn that people experience things differently and there's no one right way to experience sexuality."* Sam discussed the impact of simply having a name for a feeling

or learning that there are more options than compulsory heterosexuality and how this enabled them to begin to understand and accept their identity. She recounted how *"that was the first time I learned that romantic and sexual attraction can be separated… I thought for a long time, I am just not sexually attracted to men… so like, I guess I'm straight, but… I don't know, I don't really wanna have sex…And I was like, whoa, wait. So I can be sexually attracted to women and romantically attracted to men… I was really holding onto that 'marry a man,' ideal, and then after that I realized that I was a lesbian...It took a while, but that was my first moment of realizing that gender and sexuality could be more complex than just the binary."* Participants described not knowing or learning later on the names for the identities they now recognize themselves as. For example, Gale told the story of how he learned of being transgender, and how life changing this information was: *"I didn't know what trans even meant until I met my friend… they were like, 'oh, hi, I'm trans… do you know anything about the LGBTQ community and like, are you cool with that?' And I was like... 'what is that?' …first learning about it was like, Oh my god. What the heck? This is a whole new world I didn't even know about... you really don't know what you're missing out on, until you find out what you were missing out on."* In addition, having this knowledge was vital in the ability of LGBTQ+ participants in being able to find community, safe spaces, or identify others who could offer them interpersonal support. More than learning what sex means for them as queer people, having education and knowledge which included the reality of the spectrum of human sexuality and gender was vital to these queer young people in feeling like they could have a place they belong in their communities and in the world.

Knowledge on Sexuality and Physical and Psychological Safety

Participants' testimonies above described how the lack of information they experienced had a large impact on their mental health, harmed their ability to understand and accept their own sexuality, and left them ill prepared to engage in sexual activity safely and comfortably with a partner. Physical safety and health are areas where a lack of information is clearly understood as a barrier in the literature and are

oftentimes the only area of focus when measuring the impacts of sexuality education (Hall et al., 2016; Elia and Tokunaga, 2015; Lindberg et al., 2016; Santelli et al., 2017; Schalet et al., 2014). Participants identified how receiving education and knowledge on sexuality and related topics, such as healthy relationships, condoms, STIs, communication with a sexual partner, or consent allowed them to practice sexual wellbeing by teaching them how to be physically safe while being sexually active. They also made clear the physical and psychological risks involved in engaging in sexual activity without having received information on sexuality and sexual health, or with a partner who hasn't. Sam mentioned how *"Oftentimes it's a partner who doesn't have all the information... you might know about consent a little bit. You talked about it in health class, but that wasn't a conversation that your partner had. And then maybe they sort of... dominate the decision-making in a way that's not fully consensual."* Something made clear in participants' testimonies throughout the study was that when they were able to access information and knowledge on sexuality, they found that it was vital in understanding themselves, their identity, their sexuality, their autonomy, and understanding how to keep themselves safe; in summation, they couldn't practice sexual wellbeing without it.

Echoing the sentiments of the participants, Goldfarb and Lieberman (2021) emphasize the role of effective sex education in social-emotional learning and positive social-emotional outcomes. The authors found that aspects of social-emotional learning were included in a variety of comprehensive sex education curriculums, especially those that covered healthy relationships and interpersonal communication. They described how social-emotional outcomes from sex education included: "increased empathy, respect for others, improved communication, managing feelings, positive self-image (including body image), increased sense of self-control and safety, and establishing and maintaining positive relationships" (p. 22). Other authors and studies also note the psychological distress and poor mental health outcomes associated with a lack of sexuality information, particularly for LGBTQ+ adolescents (Haley et al., 2019; Hunt et al., 2022; Elia and Tokunaga, 2015; Santelli et al., 2017). It's clear that learning and knowledge related to sexuality are much more integral to sexual wellbeing beyond what are typically considered positive outcomes of sexuality education, more than avoidance of unintended pregnancy, preventing STIs, and

practicing consent, learning about sexuality was named as vital to understanding oneself and how to safely interact with others.

Access to Safe Spaces to Be

Having Private Spaces at Home

The idea of safe spaces was a topic which came up frequently throughout the course of the study as integral to being able to practice sexual wellbeing. Participants mentioned safe spaces as those spaces where they felt they could talk about sexuality openly, but also those spaces where they felt that they could just be. Safe spaces are places where their existence, their identity, and they themselves are welcomed, accepted, and respected. What constituted a safe space varied from person to person, and different types of safe spaces were mentioned by participants as necessary for practicing sexual wellbeing. Some participants described the importance of having safe spaces within their living spaces. For them, these were private spaces where they could be away from others with whom they share living space, where they had privacy, and were able to take time to be by themselves. As Helena described, *"In my bedroom, and my bathroom… those are… the two spaces I feel safe."* Coppella et al. (2023), emphasize that private spaces for youth in their homes where they can be both unseen and unheard are integral to their practice of sexual wellbeing. The authors describe how "boundary-making and negotiating privacy at home has been shown to promote youth wellbeing," particularly in the transition from childhood to adolescence, wherein young people may choose to spend more time by themselves and "make greater use of physical privacy markers, such as closing the door to their bedrooms" (p. 2). The participants in my study similarly mentioned that safe spaces of privacy were necessary for their mental health, as well as an important place for practicing sexual wellbeing.

Safe People who Create Safe Spaces to talk about Sexual Wellbeing

Participants also described having people in their lives, often the same person or people who they felt they could go to for interpersonal support, with whom they felt they had a safe space. They described how the strong interpersonal relationships they had made it so that being in a place with that person or people would make that a space where they would feel safe and comfortable to be their authentic selves, and speak openly about their identity, emotions, and sexuality. For example, Sam did not name a specific location as a safe place for him, and instead said, *"I feel safest around my friends, family and partner."* For Gabriela, it was her group of friends who she has known for years, who, when together, have been able to discuss sexuality openly and casually. She described how, *"Those friendships are really important and just… gossiping about those types of things and just talking about them and having fun and being in a space where you can feel safe to do that, I think is so important."*

Safe Places with norms which Create Safe People

Participants also described safe spaces in their communities as those places in which the norms of acceptance, inclusivity, respect, openness, patience, non-judgement, and solidarity made the participants feel welcome and safe, even among strangers. Participants described finding spaces like these as the first space they felt safe to be themselves outside of their home, or the first space they could be their authentic self at all, if their home wasn't a safe space to be. All participants found these spaces particularly important because of aspects of their identities or backgrounds, such as being LGBTQ+, their socioeconomic status, or having a disability, which made it difficult for them to find spaces of belonging in their home, among peers, in their schools, or in their communities. Gabriela described finding a place like this for the first time, and how much it impacted her, saying *"That was one of the first experiences where I kind of found a space where I felt like I could be myself outside of my home or with my friends and family, and so that was a really just... mind boggling thing because these were conversations I had been having before, but not with people I didn't know. And so just to be able to get more perspectives, and*

just hear about people who felt as safe as I felt in that moment, even though we didn't know each other, it was something, it was really life changing, to be honest."

In the literature, Elliot (2014) discusses norm creation surrounding adolescent sexuality within sex education classes as carrying the standard of the implicitly white nuclear family as the correct structure under which to have sexual relations. This carries clear unspoken rules governing who is considered "normal" and who is considered "deviant" which Elliot describes as a social structure which "has to be created and recreated daily through peoples' talk and performances" (p 215). These norms drive and enforce the discomfort, shame, and stigma surrounding adolescent sexuality which have a historically deep hold in U.S. policy, social relations, and institutions, and serve to disrupt community interdependence and enforce inequality (Arvin et al., 2013; Elliot 2014; Schalet et al, 2014). The participants described finding safe spaces specifically in sites where these norms are disrupted, in favor of norms of acceptance, community-building, and respect for young people and their agency as the holistic and fully formed human beings they are, without prescribing any sort of behaviors. For example, during the focus groups, participants listed the qualities they found in safe spaces, saying *"open minds, trust, confidentiality, sex positivity and/or neutrality,*" as well as "*people being patient, a calm and relaxed space, and judgement free zone."* These safe spaces can be compared to what Romeo and Kelley (2009) name as "sites" of positive youth development, which are contexts in which "wellness needs are met through relationships across personal, relational, and collective 'sites'" (p. 1003). While the authors discuss these sites generally, as they are located wherever youth are in their daily lives, they also note that because sexuality is something integral to young peoples' daily lives, these sites are also areas where discussions, interactions, and learning related to sexuality happen (Romeo and Kelley, 2009). The authors discuss the importance of positive norm creation surrounding sexuality in these sites, akin to how the participants described safe spaces as those with relations governed by the positive norms named above. These 'sites' or safe spaces, then allow young people to build relationships, have safe spaces to learn and establish support systems related to their sexual wellbeing.

Ultimately, all participants noted that of vital importance to their sexual wellbeing was having access to safe spaces where they felt comfortable simply being, expressing themselves in an authentic way, and being received with respect and acceptance. Participants illustrated what safe spaces can look like on an individual level, where participants had spaces they could go to in order to be by themselves and feel that they had privacy, on an interpersonal level, where participants were able to identify individuals who were "safe people" to them, and on the community or societal level where participants were able to identify spaces in their community where they could go to feel safe. While each participant's needs and experiences related to safe spaces varied, some expressed how safe spaces on all levels, individual, interpersonal, and societal, were integral to their practice of sexual wellbeing. Participants also noted how these spaces were also often where they went to access the sexual health knowledge and education they hadn't been able to access in their schools. Furthermore, being able to access services or resources in these spaces was also a huge support in combatting the stigma and shame surrounding accessing sexual health services, and made basic services, such as healthcare more accessible, because participants felt they were welcome in these spaces, they would be listened to, their privacy, identity, and autonomy would be respected, and they wouldn't be judged for discussing their sexuality.

Section 2: Barriers to Sexual Wellbeing

I will reiterate that sexual wellbeing was defined by the participants as the lifelong experience of exploring, knowing, and accepting yourself, including your identity, your body, and your sexuality. According to the participants, practicing sexual wellbeing means learning how to take care of yourself in all aspects, including finding out what sexuality and wellbeing mean for you, and accessing the support, education, resources, the spaces to be able to enact it. The barriers they described were those challenges, obstacles, and experiences they encountered that inhibited their sexual wellbeing, and made its practice more difficult. When discussing barriers, participants tended to start with the largest obstacle or obstacles they faced when practicing sexual wellbeing. For example, when I asked about obstacles to sexual

wellbeing in the interview, Gale said "*I would say being homeless is one of the bigger things."* Sam named two other factors: *"Definitely lack of information is probably the biggest thing. And shame and stigma."* Gabriela spoke of obstacles more broadly: *"I feel like the community that you grow up in has a big impact on whether or not you're able to access the resources you need to practice sexual wellbeing,"* and Helena spoke from her own experience: *"I came from a place where I was always shot down… no one listened to me, and being abused just made it worse."*

The barriers participants encountered varied widely, in terms of number of barriers, the degree of harm they caused, the contexts in which they were experienced, and the ways in which barriers compounded with one another in a participants' life. Most often, participants described larger adverse events or factors in their lives as barriers, or general barriers they noticed which are prevalent in society, and more universally experienced. They then would go on to illustrate the unique impacts these broader factors had on their lives and their sexual wellbeing and the ways in which they multiplied the impacts of other smaller barriers or led them to encounter compounded barriers as a result of the initial event, condition, or root cause.

The main messages of the participants were that there were underlying barriers which created obstacles in their lives as well as societal barriers present for each of us as members of our communities, and that both individual factors and societal factors present themselves in myriad, diverse, context-specific ways, which manifest in each individuals' lives differently, but can be identified by the same root cause, and may carry similar impacts on those with similar backgrounds, identities, or experiences. In participants' stories, barriers tended to reinforce one another as obstacles to sexual wellbeing. The barriers summarized here provide a sample of experiences from four young people in this study, but it is not a full or comprehensive documentation of the barriers to sexual wellbeing which are faced by young people in Maine. The main barriers identified in this study included: Experiencing violations of physical and psychological safety, security, and autonomy, such as domestic or sexual violence; receiving inadequate, incomplete, or inaccurate information on sexuality; societal silence, shame, and stigma surrounding youth sexuality; and having systemically unequal access to resources, support, education, and safe spaces. I will

discuss each in turn, however it is important to remember that barriers do not operate separately or independently from one another.

Experiencing Violations of Physical and Psychological Safety, Security and Autonomy

Difficulty Connecting with or Relating to Others

Multiple participants described experiencing forms of violence in their lives. For two participants, Gale and Helena, this violence began at an early age, in the form of abuse or domestic violence they experienced at home. This had multiple and lasting impacts on them as they grew older. They described these impacts in depth as well as the specific effects they had on their sexual wellbeing. The participants who experienced domestic violence, abuse, or neglect in their home environment as they grew up described having difficulty reaching out or connecting with others, especially their peers in school. They described feeling alone and isolated as children, afraid to express themselves or unable to find others to relate to in school. Gale described this, saying *"I was very quiet and abused in my childhood. I didn't really talk to people and I was the kid, they saw bruises but weren't gonna say anything"*. Helena also shared experiences of isolation when she described how in school, *"no one wanted to be my friend."* This isolation impacted their abilities to be able to access interpersonal support, identify "safe people" or somebody they could talk to, and posed an obstacle for them in finding spaces where they felt they belonged. This difficulty, and the compounding experiences of this isolation, is described by Helena, as she felt ostracized from her peers and society as a whole. She recounted how, *"When I was younger, and when I was growing up, I didn't have that person who I could count on. I didn't feel like anyone wanted me. Because I had some behavior issues, and... I got made fun of a lot, so I find also that reaching out to society is very hard for me, because I often feel I don't belong in the world. So, I tend to shut down."*

Given the importance participants placed on safe places and healthy interpersonal relationships in being able to process, understand, and explore their own sexuality, having an unsafe or unstable home life where one experiences violence is an inhibitor in itself, as these participants were not able to feel safe in

their home, or go to their family for support. This clearly posed a large barrier to these participants in being able to access safe spaces, as the norms which may allow them to feel safe in a space were not modeled in their homes. The violence they experienced in their homes growing up also proved to be a catalyst for compounding barriers given the difficulty these participants faced in reaching out to others outside of their home, who may have connected them to safe spaces. The impact this had on their ability to find safe spaces also likely contributed to their difficulty in finding interpersonal support, as participants described, in many cases safe spaces can lead a young person to interpersonal support, and vice versa.

The impacts of experiencing violence on one's health and relationships have been documented in the literature, including in the literature on sexual wellbeing. Mitchell et al. (2021) include factors such as "resilience" and "forgiveness" in relation to past sexual experiences as domains of sexual wellbeing and describe how responses to adversity and trauma and avoiding self-blame, shame, and self-stigmatization are key to maintaining mental health and relationship quality in enacting sexual wellbeing. However, these definitions only describe how sexual trauma relates to sexual wellbeing. Lorimer et al. (2019), found that among 162 papers on sexual wellbeing produced in the past decade, 16 mentioned violence, including domestic abuse, child abuse, partner violence, or sexual violence as an influencing factor of sexual wellbeing. Only half of those 16 papers included analysis based upon people's lived experiences. Studies which did include violence revealed the significant and lasting impact of violence and trauma on sexual wellbeing, in particular, impacting the relationships of those who have experienced trauma, and posing a barrier to forming healthy relationships. This impact is described above by the participants in their own words. They offer an inside view of the emotions and feelings they had which inhibited them from connecting with others and forming healthy interpersonal relationships with others. In this way, the participants offer insight which is vital but often omitted from explorations of sexual wellbeing.

Experiencing Violence as an Obstacle to Education

The participants also noted the impact their unstable home lives had on their ability to access education or learn in school. Helena described how despite attending her required sex education course in school, she was unable to learn: *"When I was in high school, I didn't come from a stable home... So I was already struggling and in school I had a really hard time… In high school, you are required to take sex ed…But I really couldn't focus. And so, I went, but it just was not great. That just made it suck."* The instability of her home life and the isolation she felt as a result made it difficult for her to focus in school or engage with the material that was taught in her sex education class. Gale didn't receive sex education in high school, as he was forced to drop out of school in ninth grade, when the violence he experienced at home culminated in him no longer being able to stay there. He also pointed out the lack of support in school for young people facing his situation: *"I had to drop out 'cause I was homeless. I didn't know much about McKinney Vento laws, so I couldn't access those…McKinney Vento law… protects students … you're guaranteed transportation to your school so you don't have to switch schools or…you could switch schools and immediately start, and not have to wait for vaccination records, medical records, papers parents sign off of, which is good for runaways or homeless youth so they can immediately be enrolled in school... And not waiting for a parent's permission or… it can be that the liaisons can step up and actually sign… for the youth… But, I didn't know about that back then. And... McKinney Vento liaisons are just now being put in every school, and actually learning what their job is, 'cause half the time it was counselors and it was part of their job, but they didn't really know how you do it."* The McKinney Vento laws he is referring to were put in place to support students whose unstable home situations impact their ability to access education. The laws are supposed to ensure that these students can remain in school, even while their housing situation is uncertain. However, as this participant brings to light, the implementation of these laws in Maine is inconsistent, and many school administrators do not even know they have the power and responsibility to uphold these laws, leaving young people who find themselves in unstable home situations without knowledge of their rights to education.

Participants who experience violence at home then face another barrier to sexual wellbeing, in terms of limiting their access to education, which, as they understood it, is vital in being able to

understand and practice sexual wellbeing, knowing oneself, and being able to maintain one's physical sexual health as well as emotional wellbeing related to sexuality. The literature also describes how young people who have experienced or are currently experiencing trauma engage with sex education and sexuality differently than those who have not had those experiences (Broussard et al., 2019). Broussard et al. (2019), describe how trauma survivors have unique and various emotional needs, and how trauma also plays a large role in young peoples' sexual decision-making and ability to be safe and assert boundaries in sexual encounters. Thus, individuals who have experienced trauma, and in particularly, sexual trauma, will engage with sexuality education differently than others, in emotional ways which are typically left out of CSE approaches which are not trauma-informed, meaning they do not include consideration of the past experiences of those who are receiving the information (Broussard et al., 2019). Moreover, as mentioned in the literature review, CSE often omits discussions of emotions related to sexuality completely. These omissions impact the ability of those who have experienced trauma to engage with the material, if they can engage at all.

The testimonies here also demonstrate the shortcomings of mainstream and systemic supports which may improve sexual wellbeing in that there is a difference between a resource being available, and it being accessible. In the experiences described by participants, there are laws in place designed to ensure that youth receive sex education in school, and youth experiencing homelessness can stay in school, but, these resources may not be accessible to those who need them, because of a lack of knowledge that they are available, a lack of support in accessing them, a lack of broader context for the issues they are attempting to address, or other external and unrelated inhibiting factors related to experiences of violence or abuse.

Compounding Risks to Personal Safety

The participants who described experiencing abuse or neglect in their homes growing up also recounted experiences where their lives were at risk because of difficulties they encountered in being able

to take care of themselves after years of abuse. Helena described struggling with mental health, low self-esteem, self-harm, and suicidal thoughts, saying *"back then, when I tried to speak, I got shut down and at that point I'm like, you know, I'm just going to kill myself. I almost was successful too… I still struggle with self-harm."* Gale told a story of how he struggled to find a reliable support system outside of his house and flippantly described nearly dying as a result: *"So when I was kicked out by my mom… I peaced out, literally had a backpack full of things... I ended up getting hypothermia, and I literally froze to my own tears. I was only like wearing ripped up jeans and a flannel so I called 911 on my dingy flip phone, my mom took away mine [smart phone] and bought me that... Thankfully they found out where I was... I was dragged out, like half conscious. They couldn't get my temperature up and... I thought I was gonna die. But it ended up being fine, and like my temperature was up within, I dunno, six hours or something... I've had a lot of close death experiences in my life. So it doesn't really phase me anymore, but, I forgot what the question was by the way."*

The literature clearly draws a link between adverse childhood experiences such as physical, emotional, or sexual abuse or domestic violence, and increased psychological and social stress, as well as increase of risk-taking and harmful behaviors, including substance abuse, unprotected sex, and self-harm (Broussard et al., 2019). However, participants described their psychological distress directly as the root of these risk-taking or harmful behaviors, problematizing the view of youth sexual health which centers young peoples' individual decision-making ability as the largest influence on their sexual health. The participants offer illustrations of the assertion that decision-making is governed by a myriad of factors outside of the control of young people, including their past experiences, and access to safety, resources, information, and support. The participants made it clear that experiencing violence or instability at home, growing up not being able to rely on the support systems which were supposed to protect and care for them as children had long lasting impacts on their mental health and ability to take care of themselves to the point where they struggled with survival, of both the abuse they faced and the compounding psychological harm this abuse caused them.

This array of barriers participants identified originating from domestic abuse points to an important omission in discussions of sexual safety, health, and wellbeing. The experiences of violence described by the participants in this study are not especially uncommon among young people in Maine. Domestic violence in Maine has been named as a public health issue, as nearly half of all homicides in Maine each year are the result of domestic violence (Park 2016). By discussing their unstable or abusive home situations as a major barrier to sexual wellbeing, the participants reveal the importance of including violence and experiences of abuse in discussions of sex education and sexual wellbeing, and the need to further look into the impacts of these experiences on young people. This need is emphasized in the literature, as domestic violence is not often seen in measurements of sexual health or sexual health curriculums, and when it is, it's usually relegated to information on intimate partner violence, or unhealthy romantic or sexual relationships between young people, with little attention to other forms of violence young people experience, such as domestic abuse or child abuse (Lorimer et al., 2019). The impact of experiencing these types of abuse is therefore left out of discussions of sexual wellbeing, despite the impacts of these types of violence on victims' mental health, future access to safety, and self-image, and the importance of those factors within sexual health and wellbeing. Including these experiences of violence was vital to understanding how the participants who experienced them conceptualized and practiced sexual wellbeing.

Harm from Violations of Autonomy

Both participants who described experiencing domestic abuse at home, also experienced elements of abuse related to their sexual healthcare as kids entering puberty. Both also self-identified as having disabilities. They both were put on the pill without their consent and expressed dismay at the impacts it had on their bodies. Experiencing sexualization and sexual stigma and being put on contraceptives at a young age was another barrier to sexual wellbeing experienced by the participants who faced abuse in their homes. As Gale described: *"I've been going to family planning since I was like, 11. [My] mother,*

when I was younger,... used to call me a whore, even though I didn't do nothing... she was always convinced I was going to get pregnant or something, so I've been on birth control since I was really young… [She] kind of forced me to do it...it's not good for your body." Having this first introduction to sexuality be a negative, punishing, and coercive experience, and being shamed for even potential sexuality, illustrates the large barrier created for participants in being able to engage with sexuality or in sexual relations in a healthy way until later in life, especially because of the impacts of the other barriers they faced to accessing healthy interpersonal relationships, and education.

Helena described not knowing what sex or birth control was even though she had been on it for years, and only finding out after she were out of high school, because she wasn't able to learn in her high school sex education class. She talked about how *"even now, my family is like, you should get your tubes tied. I'm like, no. 'Cause someday I want kids. 'No, no, you can't even take care of yourself, so how can you take care of kids?' Thanks."* Her family's attitude towards her sexual and reproductive health reflects an undermining of her reproductive autonomy and discriminatory views towards her right to parent. Viewing this experience through a reproductive justice lens situates it within the long history of the undermining of reproductive autonomy of people with disabilities. Ross and Solinger, (2017) describe how "parents may decide to sterilize their disabled child before she has reached the age of consent, a coercive and life-changing act that could express society's disinclination to allow that particular body to reproduce" (p. 94).

Historically, people with disabilities have been subject to reproductive oppression in a specific way, enacted through the regulation of bodies, autonomy, and standards of sexuality, people with disabilities have been subject to forced sterilizations, limitations on their reproductive autonomy, and violations of their rights to parent, including discrimination in child custody, parenting their own children, and adoption (Engelman et al., 2019). As Kattari (2023) writes, people with disabilities are often seen as "naive, innocent, unable to consent, and therefore are viewed as nonsexual members of society, or conversely, simply by being sexual AND disabled, they are labeled as hypersexual, as promiscuous, even as freaks" (p. 13-14). As targets of the eugenics movement, people with disabilities were seen as 'unfit'

for reproduction, and as a result, children with disabilities have long been subjected to, and continue to be subjected to coercive actions against their own sexuality as they enter puberty. These limitations on reproduction and sexuality have their roots in the same colonial-capitalist model which named heteronormativity and heteropaternalism as the only acceptable conditions of human sexuality. Just as the nuclear family was needed to produce citizenry as laborers of the nation-state, "[c]apitalism demanded intact, interchangeable bodies as grist for the mill of industrialization." This led to the creation of disability as an identity category, and "conflated disability with burden... due to capitalist values of productivity as worth," as industrial capitalism demanded familial structures which centered labor and required it from family members who would otherwise be caring for those who needed it in their families, who would now be considered unproductive citizens with disabilities (Kattari, 2023, p. 15). Practices of coercive or forced sterilization and the restriction of reproductive and sexual autonomy of people with disabilities continue, despite laws in place requiring equal treatment, as well as equal medical treatment for people with disabilities (Kattari, 2023). These norms which devalue people with disabilities as having less worth than able-bodied people, and having either no sexuality or hypersexuality are perpetuated and reproduced in society down to a household level, enacted by the parents of children with disabilities, as seen in the testimony of Gale and Helena. These norms continue to have significant impacts on the sexual wellbeing of young people with disabilities, as they are continuously denied information, respect, and agency as sexual beings.

Gale described having difficulty forming healthy interpersonal relationships, as he experienced sexual violence and found it difficult to assert autonomy sexual relationships, particularly while he was experiencing homelessness: *"Personally for me as a younger youth, my sexual wellbeing was way off. I, you know, had some situations where my body wasn't mine, if you know what I mean. So, you know, that threw everything off for me for a very long time. And that happens with a lot of other youth also. So it's kind of hard to practice that in unsafe situations."* This experience in itself also had lasting impacts on his ability to practice sexual wellbeing, adding to the barriers he already faced. He described how difficult it is to practice sexual wellbeing under circumstances where he was unsafe. The two participants who

experienced unsafe home environments demonstrated exactly why this is the case. Gale also described seeing other homeless youth in situations of sexual violence. This testimony indicates that sexual violence among youth experiencing homelessness may be a larger issue, given the difficulty this participant found in accessing support and resources at their school or community as a young victim of domestic abuse.

Sam told a story of how they talked to their partner about an experience he had where he felt that his autonomy or boundaries had not been wholly respected: *"My partner has OCD, and… her biggest trigger is substance use and she told me that was because of an incident that happened to me sexually that involved substance use and like, questionable consent… and I didn't realize that that was, like, difficult for her, and that a part of it came from wanting to protect me from something like that happening again… then I was talking about how I viewed that as kind of a nuanced experience and not so black and white about either consent, or not consent and how that sometimes... still makes it difficult for me to have sex and be fully present."* This participant alludes to the complexity and multiplicity of sexual experiences, and the feelings related to them, especially in potentially unsafe situations or where substance use is involved. She brings to light this feeling of not being able to clearly identify if a sexual experience was assault or coercion or consensual and autonomous, or even not feeling a need to, given the nuanced nature of sexual encounters.

This is not uncommon, as 60% of women who experienced nonconsensual experiences did not consider them to be assault (Kilimnik and Meston, 2019). This complexity within instances of sexual intimacy is rarely discussed, but alludes to the confusion of all parties in a potential situation of sexual assault, where having sex without a clear understanding of your own or your partners' boundaries, because of a lack of self-awareness, substance use, lack of communication, or an abundance of other reasons, has the potential to leave all involved feeling uncomfortable, violated, guilty, or unsure if what happened was assault or not (Kilimnik and Meston, 2019). In this way, the participant situates their experience as outside of typical narratives of sexual assault, which may characterize those who commit sexual assault as deliberately violent or aggressive and victims as passive or helpless (Kilimnik and Meston, 2019). Blueprints of assault maintain myths surrounding sexual violence within which actual

victims or perpetrators of assault may find it difficult to see themselves, given the way it reduces the agency of those involved in the encounter to images of a masculine perpetrator and a feminine victim rooted in traditional gender roles (Kilimnik and Meston, 2019; Arvin et al., 2014). The participant does not characterize his experience as assault but sees it in more of a gray area. However, they make it clear that even a nuanced situation such as this, had impacts on their mental health and ability to feel safe and comfortable during sex. They pointed out the negative impacts that this event had on their own life as well as their partners' mental health and both of their abilities to feel secure while having sex.

Another important piece of this testimony is how Sam felt that being with their partner is a safe space for them, and she emphasized how being able to have conversations like this with them, often discussing emotions and insecurities which come up during sex, is integral to her sexual wellbeing. This points to the integration of all aspects of sexual wellbeing being necessary to fully practice it, given the self-knowledge and self-acceptance, information on consent, interpersonal support from their partner, and the safe space which was required for them to engage in this conversation. The participant offers an example of the spaces and situations where sexual wellbeing is practiced, and its necessity for unpacking difficult and potentially traumatic subjects such as nonconsensual or coercive sexual experiences.

Silence, Shame, Stigma Surrounding Youth Sexuality

Shame Surrounding Sexuality on the Societal Level

Another major barrier that participants identified was silence, shame, and stigma surrounding sex and sexuality in their families, communities, and society. Repeatedly, the theme of silence will arise as we discuss barriers, described in many forms, such as not having anyone to talk to, not knowing what certain terms mean or what sex is, feeling shame when even thinking about sex; this silence, a collective unwillingness and uncomfortableness with the topic of sexuality, and the shame it causes for young people is nearly omnipresent in participants' testimonies. They described how these societal rules not

only enforce silence surrounding sexuality, which sends the message that it's a taboo topic, but also prescribe shame around it, further preventing communities from talking openly about it. Gabriela describes this, saying *"The society that we've grown up in… there's so much shame… that we're taught to feel if we're just thinking about sex or anything that that considers. That shame is something I've struggled with"*. Other participants also made this same point, shedding light on the dissonance between the universality of human sexuality, meaning we all experience it, and the collective inability of us, as a society, to talk about it. As Sam said, *"I wish that people… didn't think of sex and sexual health as so, inappropriate, taboo, adult… Because it's really something that's for everyone, and it doesn't have to be talked about in a way that's gross or taboo."*

Schalet et al., (2014) note how "discomfort with adolescent sexuality runs throughout the diverse institutions of American society" (p. 1597), causing pervasive silence surrounding the topic, imbued with the idea that young people are "too young to know about sex but too sexual to be given information on the topic" (Hunt, 2022, p. 467). This sexual propriety carries the underlying 'sex negative' notion that young peoples' sexuality, is dangerous, dirty, and deviant. This 'sex negative' view is a lasting result of the heteropatriarchal and heteropaternalist notions which have been the basis of the U.S. societal standards of sexual behavior for centuries (Arvin et al., 2014; Hunt, 2022; Elia and Tokunaga 2015; Slominski, 2020). Participants not only acknowledged the existence of the norms of shame surrounding sexuality in society as they are reproduced in political, social, economic, legal, educational institutions, but they also described how these larger societal norms manifested in their daily lives and impacted their personal sexual wellbeing, illustrating the blurred lines between what we might consider societal level and individual level barriers to sexual wellbeing. As Gabriela expressed, *"I feel like society, it's just like, with all of the made-up rules and laws and things that have been imposed to society, imposed on all of us, they're manifested in very real ways."* Participants gave different examples from their lives illustrating how this shame has manifested in palpable ways in their homes, communities, and schools, but specifically emphasized the shame, taboo, or impropriety surrounding sexuality that is *everywhere*. They expressed how growing up with these omniscient norms meant that even before they knew what it meant,

whether or not anyone explicitly informed them that it's shameful, they were aware of the stigmatization of sex and sexuality and were driven to maintain the norms of silence and feel shame as they began to explore it for themselves.

Family/Community Norms of Silence Surrounding Sexuality

Participants pointed out that a large contributing factor to feelings of shame surrounding sexuality was silence among their families and communities. Participants acknowledged this barrier within and outside of their own experiences. For example, Gabriela described how not being able to have interpersonal support surrounding sexuality from one's family poses a large obstacle to sexual wellbeing. In this example, the participant notes: *"maybe your family's religious or political beliefs act as a barrier to you because you don't have that opportunity to talk openly with the people who are close to you."* Gale explained that silence can exist even among families which are more accepting, and how, even if sexuality is not explicitly taboo, but simply not a topic that's openly spoken about, it can pose a barrier to learning about sexuality. He described the silence arising from *"[j]ust not having... an open family, so you can't really learn because it might be accepted, you know, but... not really talked about or explained."*

Participants especially noticed the prevalence of this silence among adults and older adults in their life surrounding sexuality. As told by Gale, *"Our older community… most of them, it's like, hush, hush, don't talk about it.... I wish it was... more accepted to talk about with the older community… That's like one of the biggest things for me…especially grandparents, like…everyone's grandparents I've met are just like, 'we don't talk about that in this household. No.' Like, 'oh my God. My bad' … just our older communities being more … open-minded, um, would be cool."* This made it difficult for him to reach out, ask questions, or access the interpersonal support vital for practicing sexual wellbeing. Gale pointed out how this silence sends the message of *"if you know, then you know, if you don't, then don't ask,"* leaving him unsure where to go for help, information, or resources.

Participants described the harm these attitudes caused in their ability to access interpersonal support and information. As the literature explains, the discomfort among adults to talk about sex with young people arises from the adults' own experiences of the same silence, lack of education, enforced heteropatriarchy, and stigma surrounding sexuality that the participants are naming as significant barriers to sexual wellbeing (Bishop et al., 2021). These trends of silence and shame have been deliberately upheld and reproduced in society by those who govern sex education, and who create norms of how we talk about sex. Elliot (2010) notes how these norms are reproduced on a household level, as parents tend to be particularly uncomfortable discussing sexuality with their own children and tend to either infantilize or demonize young people, "not think of their own teenagers as sexual subjects," but see other young people as highly sexual (p. 205). Elliot (2010) describes how often, parental conversations took the form of warnings to their kids, as parents "cannot envision any good coming from teen sexual activity" (p. 206). In this way, adults can deliberately or inadvertently perpetuate the same silence and fear-based views on youth sexuality which prevented them from accessing the information, now being denied from their adolescent children. These adults may not even know "that it's a thing to be thinking about," let alone have the communication skills or knowledge needed to discuss the subject with the young people in their life.

Further, young people may find it difficult to engage with the adults in their lives or may not think asking them questions about sex is a viable option because of the way adults, and particularly older adults' sexuality is stereotypically and falsely viewed as declining or nonexistent. Similar to experiences the participants described, adults and older adults often suffer in silence and shame and feel uncomfortable expressing themselves because of stigma surrounding their sexuality (Freeman et al., 2014). This can contribute to trends mentioned in literature and by participants of intergenerational conversations and parent-child communication surrounding sexuality having uncomfortable or prescriptive undertones, ageist assumptions about sexuality, or not occurring at all because of these deterring factors.

One participant described how "*Different communities think differently about sex and sexuality,"* and the impact this can have on a person's ability to access sexual health resources and support, if their community isn't accepting or open about sexuality, compared to somebody who grew up in a home where discussing sexuality was normalized. In this way, they demonstrated an understanding that the stigma, shame, and taboo related to sexuality is not evenly distributed within society, with some seeing their sexuality more or less accepted than others (Bishop et al., 2021; Goldfarb and Lieberman, 2021; Elia and Tokunaga, 2015). Gale described how it was unacceptable to discuss sexuality in his household and in friends' households. He considered it unsafe to even mention the LGBTQ+ community, preventing him from being able to access a safe space to be. He expressed that he wished to be able to talk about sex and sexuality openly at home without shame or fear, even if the adults in his life wouldn't be able to offer information or support, saying, *"Yeah... Like, not so much… having to engage or participate, but like just being around the conversation and being okay with it, would be fine with me too."* Given the way participants emphasized the importance of being able to speak openly with - and ask questions of - those close to them, the discomfort or silence of families and communities around conversations about sexuality posed a significant barrier to sexual wellbeing.

Shame and Stigma as a Barrier to Accessing Resources and Care

One area where participants found that this silence and the shame that accompanies sexuality was particularly impactful was as a barrier to accessing resources, including safe sex tools, and sexual healthcare. For example, Sam emphasized, *"Definitely lack of information is probably the biggest thing... and shame and stigma, because … there are people who… want to use condoms or be on birth control… but they feel such a shame to go buy condoms or talk to their doctor about birth control."* Further, the idea that young people should not be sexually active, and that youth sexual health should be centered around preventing STIs, pregnancy, or violence can pose a large obstacle in young people being able to access sexual health services or things they require to be safe. Sam also expressed frustration at how

divorced that idea is from the realities of youth sexuality and the needs of young people, saying, *"She [health teacher] had condoms, but she wasn't allowed to give them to people... people think if you give students', condoms, they're going to have sex. But really... they're gonna have sex no matter what... don't we want them to have safe sex? And then in places where you're allowed to give condoms, but not lube, and it's like, lube is a safe sex tool as well 'cause you want the condoms to stay intact. Like… they don't want you to enjoy…the lube will make it feel good. You don't want that."* In this way, Sam pointed out how the idea of young peoples' sexual pleasure is so stigmatized that their access to safety suffers as a result. This stigmatization of pleasure, and particularly young peoples' sexual pleasure, is widely noted in the literature as a clear gap in global messaging related to sexual health, sexuality education, and as a consideration in overall wellbeing, in favor of messaging on fear, danger, disease, and prevention (Ford et al., 2019; Goldfarb and Lieberman, 2021; Yee, 2010).

The way that participants also emphasized the shame and stigma they feel related to their sexuality as a significant barrier to sexual wellbeing is revealing in the ways in which historical norms of sexual propriety discussed in the literature review are continuously reproduced in homes and schools, in places in their communities, sites of accessing healthcare and in greater society. Silence and stigma were at the root of many of the barriers described by participants, and the shame, isolation, and exclusion participants felt as a result proved to also have compounding impacts on other barriers. This testimony sheds light on why gaps in formal sex education haven't been filled by parents or healthcare providers, and why young people don't feel comfortable speaking up about sexual health when they do visit their providers, and find that there are few places, if any, they do feel comfortable speaking about it. Their testimonies demonstrated the emotions experienced as a result of the heteropatriarchal and colonial norms stigmatizing "deviant" sexuality and sex outside of reproduction and indicated the interlocking nature of the barriers to sexual wellbeing, and the need for multifaceted approaches on all levels (individual, community, and society) to address them.

Inadequate, Incomplete, or Inaccurate Information on Sexuality

Education was a part of sexual wellbeing where participants encountered significant barriers, through a lack of access to information, inadequate information, or encountering harmful information. Each of the four participants did receive formal sex education in their schools at varying points in their education. However, each participant described in depth the way this sex education was inadequate in providing them with the knowledge necessary to practice sexual wellbeing. Some received no information at all in class, as Gale illustrated: *"My gym teacher, this ancient old man, was my sex ed teacher and instead of actually teaching us sex ed, he would put football games on all day. So we didn't learn anything."* Throughout the entire interview and focus group process, only Sam had any positive things to say about their sex ed experience or brought up anything they had learned in their school-based sex education class, saying, *"I remember we talked about consent, so I felt like that was pretty good compared to like, you know, the horror stories of what some people learn in sex ed."* However, participants brought up again and again how the sex education they received was limited, by the scope of the information offered, the attitude of their instructor(s), the classroom environments they were in, and/or the attitudes of their parents.

Incomplete Sex Education

Participants described the innate limitations of school-based sex education. Their experiences indicated how allowing for students to be exempt from sex education, and only teaching sex education in one or two courses throughout a person's life, will inevitably leave them unprepared for the lifelong realities of human sexuality experienced before puberty and onward. Gale was exempted from the elementary level sex education that was offered in his school by his parent, was shown football games instead of sex education material in middle school, and then was forced to drop out of high school when he became homeless, leaving him without a support system as a young teen and with no knowledge that sexuality and sexual health were *"even something to be thinking about."* Here we can see how barriers

compounded for this participant. He described how his home environment was the largest barrier to him in practicing sexual wellbeing, as he was denied safety, agency, and information as a child, then lost access to education altogether when he became homeless and had to drop out of school. He described how it felt to have grown into an adult without having received vital information on sexuality that adults are assumed to know already, saying *"as adult, who are you gonna ask? … Friends. Yes. But like there's not like really any educators…. when I was younger, you didn't see adults talking to other adults about sexual wellbeing."* Despite sex education being offered in his elementary school, and early life sexuality education being something shown to improve sexual wellbeing among young people (Goldfarb and Lieberman, 2021), this participant was not able to access it because of the attitudes of his parent towards his sexuality, and because Maine law allows for students to be exempt from sex education classes ("Maine State Profile," 2021). Gale points out how, being denied access to sex education as a young kid, he didn't see these conversations on sexuality happening outside of sex education classrooms, even between adults, and how this left him feeling confused and isolated as he grew into a young adult with no support or information from home or elsewhere, not knowing where to go for interpersonal supports, resources and services, or even a safe space to be as he began to explore his identity and sexuality. This testimony demonstrates how despite the requirement of Maine youth to take formal sex education, even when the class is offered, instructors and parents have significant power in allowing or disallowing access to any sex education for young people.

Gabriela pointed out that any sex education, regardless of how comprehensive the curriculum is, will be limited in providing vital knowledge for practicing sexual wellbeing, saying *"Just the way the curriculum is taught in school... no matter if it's perfect... it can't encompass everything."* The participants alluded to the fact that the human experience of sexuality isn't something that can be taught in a classroom, no matter how much time is allocated for it, no matter the quality of the material offered, because of the nature of sexuality and sexual wellbeing. Going back to the definition participants gave of sexual wellbeing, practicing sexual wellbeing is a subjectively experienced lifelong process; not something you can access without lifelong learning. The participants point out the limitations of

classroom-based sex education which is assumed to cover all of human sexuality in one course, lacks continuity and ends before adulthood, never to be revisited. As participants point out, everything cannot be covered in an elementary, middle school, or high school sex education classroom. Even if they received the most inclusive, comprehensive, informative sex education possible, young people cannot be equipped in one class, for something that is entirely unique to them, and spans their entire life. In this way, a barrier for all participants was incomplete sex education.

Classroom Environment that is Not a Safe Space

Participants identified another major barrier to education in their inability to feel safe and comfortable in their sex education classes at school. Gabriela described the discomfort implicit in talking openly about sex for the first time, especially if it's in a setting surrounded by peers, and with an educator who you may not know. *"When we're kind of in these settings and talking about sex for the first time, it can be a little overwhelming. And I think that some of the way that comes out is judgement, both towards ourselves and other people."* She went on to emphasize how, *"If you're able to be in a space where you can talk through it while also feeling safe and comfortable it's really good. And that's very contrasting to me, from my ideas of freshman health class, like sitting in a dingy room, talking about it with a bunch of people around me, it didn't really sit right."* Safe spaces were identified by participants as one of the fundamental pieces of sexual wellbeing. Being able to have a place where they feel comfortable, respected, and known and accepted as their authentic selves was what allowed them to be open to learning and talking about sexuality. Participants described how they and their peers did not feel as though their sex education classes could be considered safe spaces. They described not being able to learn or ask questions because of feeling judgement and not feeling like their privacy would be respected. As Sam described, *"Nobody wants to raise their hand in front of the whole class and ask a question like that… even when teachers have anonymous question boxes, they know your handwriting from your tests and… it doesn't feel always like a truly safe space."* Helena described facing harassment by peers, and feeling

like her instructor didn't care about her, saying, *"in that class, the students made fun of me and the teacher never really paid attention to me, and… I felt like I couldn't belong."* No matter the material, participants described how a sex education classroom that didn't feel like a safe space couldn't be a space of learning for them. Participants pointed out one of the major barriers to effective school-based sexuality education. Namely, students need to feel safe and comfortable in order to be able to engage with information and learn, particularly about topics which are so personal, and already have so much shame attached to them, as sexuality.

The Problematization of Youth Sexuality in Sex Education Class

The one participant who had described having a positive sex education experience also noted that despite learning about consent and receiving in-depth information on STIs and contraception, the education they received was limited by the requirements for what must be said in sex ed classrooms. Sam described how this played out in his sex education class: *"I mean she [health educator] had her own barriers too of what she was and wasn't allowed to do… she had to say, like 'The only a hundred percent way to prevent pregnancy and STIs is abstinence'... basically her ending point always had to be abstinence, just kind of mandated."* This emphasis on abstinence described by the participant is, in fact, a mandate within Maine sexuality education (Maine State Profile, 2021). It is a remnant of abstinence-only education that has persisted in CSE, where sex education includes information that is considered comprehensive, but also must include prescriptions against young peoples' sexuality with continued mentioning of abstinence (Elliot, 2014). Sam expressed how this approach leaves students with unanswered questions and a lack of information, saying *"I realized how many people are like secretly wanting and needing these conversations, but they can't speak out… how stigmatized something that's so healthy and normal is."* The participant also noticed the silencing impact which occurs when sexuality can only be discussed with young people in tandem with abstinence, preventing the occurrence of open discussion of sexuality in sex education class, as it becomes clear to young people that their sexuality isn't

something that is viewed as *"healthy and normal"* in that space, but rather something adults would like them to avoid.

This testimony demonstrates how when the space given to young people to discuss their experiences of sexuality is a classroom environment where they are receiving the message that they are putting themselves at risk if they are being sexually active, they are not likely to feel as though they are safe to engage with the material, ask questions, or feel comfortable enough to be open to learning, even if they have an unanswered question on their mind. Shame and stigma surrounding sexuality in society, in households, and in communities is clearly perpetuated in sex education classrooms, the one readily available space within young peoples' communities which is supposed to be where young people can discuss and learn about their own sexuality. Instead, a continued focus on youth sexuality as a problem behavior renders sex education classrooms sites of discomfort and continued shame, preventing students from learning and accessing vital education and knowledge they need to practice sexual wellbeing.

Omissions of LGTBQ+ Sexuality and Gender Diversity in Sex Education Class

Participants discussed how another barrier in accessing information and education was the heterosexual lens of their sex education courses, which omitted LGBTQ+ experiences and the realities of gender diversity. Sam was the only one who described her sex education experience in any sort of positive way, but still brought up the mental distress and anxiety they experienced when she learned of sexual health through a heterosexual lens but were left without any information relevant to them as a queer person. As she said, *"I had a decent sex ed class… But even a decent sex ed class is so lacking, where, you know, it wasn't abstinence only. They taught us a lot of important information, but on the other hand, they didn't teach us anything about queer sex. And so I had all these anxieties and misconceptions about what queer sex was."* This participant also described the omissions related to their sex education material being limited to binary gender, *"[there was] this activity that was like, These body parts belong to men, women, or both? and it was anatomy terms,"* as well as receiving different materials

based on their assigned gender at birth, saying *"I remember being in middle school… And I had some health class before then, but it was very, very limited... some of the things that I hadn't learned in school at that point were, anything about erections or male anatomy. I'm pretty sure we had just had the period talk and they separated the room into gender binaries."* This left them without key knowledge on the realities of human anatomy, sex, and sexuality. They noted that they had no idea intersex people existed, because of the language used to describe anatomy in sex education class which did not acknowledge the existence of trans or intersex young people. *"My mind was blown when I found out that intersex people existed and that was something we never talked about in health class. And also hearing the statistic that it's as common as being a ginger. I was like, that blows my mind. 'cause that means I've actually met intersex people and just had no idea."*

Gabriela described how it felt to not see herself reflected in her sex education, and how it impacted her ability to feel like she fit in or belonged. As she said: *"A lot of the curriculums in schools, they're very heterosexual and heteronormative. And that's the way we're kind of taught to kind of think about sex and sexuality. So when you kind of differ from that ideal… it's automatically a little bit harder to deal with and tackle those feelings and then to realize that, oh, I need to be looking somewhere else… for help to figure out kind of how I fit in and stuff."* She came to the realization that she was not going to be able to get the information she needed from the sex education she received and understood that she was going to have to look to outside sources to get her questions answered and to access information, resources, and support so that she may practice sexual wellbeing.

Participants described having the idea that there's a way that sexuality *should* look, that there's a way you *should* feel, and grappling with experiencing something different than the norms of sexuality they had internalized. In this way they identify their sex education classrooms as a site of reproducing the hetero-paternal-patriarchal norms of sexuality which have served as the societal standard for sexuality in U.S. for centuries. They also illustrate the psychological, emotional, and mental harms caused by the perpetuation of these norms, and the isolation and exclusion they felt by finding themselves not aligned with these standards of "propriety." Again, in this testimony we can see the harmful impacts LGBTQ+

exclusion can have on queer young people, particularly when they aren't represented in sex education, but also the harm caused to all young people when information on the realities of the breadth and diversity of human sexuality is censored or omitted from conversations or information on sexuality and sexual health.

Limiting Conversations on Young Peoples' Sexuality to Physical Safety/Risk

Participants identified a barrier in the way their formal sex education in school omitted the psychological and emotional parts of human sexuality. School-based sex education did not breach the realities of young peoples' sexuality, and what their experiences may look, feel, or be like, except in the case of preventing STIs or using birth control. For example, Gabriela discussed how this impacted her knowledge of sex itself: *"I had taken a sex ed course, but, obviously those were pretty not all-encompassing. So what I knew was relatively technical, but then not even really."* Sam echoed this statement, saying *"My health teacher, everyone loved her. She acknowledged the existence of queer sex, but there was no details about anyone's sex, it's like, you know, sex, you could use your genitals, your hands, or your mouth. And that was like kind of the blanket of that. But then we got to learn about more specifics when it came to contraceptives and STIs...which is important, but our psychological safety matters too, not just physical safety."* Participants pointed out that a focus on STIs, contraception, consent, and violence prevention are large and important pieces of sexual wellbeing. However, to only focus sexuality education on these aspects of sexual health omits key parts of human sexuality, including those aforementioned psychological foundational pieces of sexual wellbeing such as self-acceptance, supportive and intimate relationships with others, and understanding what sex is for you. Participants pointed out that these vital lessons, "*learning not all experiences are the same,"* are rarely included in sex education courses or curriculums, and that their omissions posed a barrier to them being able to practice sexual wellbeing.

These sentiments of participants echo those of Maine public school students reported by Nevins and Johnston in 2017, where experiences of missing information and negative and uncomfortable

classroom atmospheres were common among Maine students. Students reported feeling that they did not have the materials, anonymity, privacy, or safety they needed to learn in Maine classrooms. They described similar experiences as the participants in this study: fear of asking questions, negative classroom atmosphere, not feeling like sexuality was something to be discussed outside of the classroom, and a lack of discussions of emotions (Nevins and Johnston, 2017). Similarly, participants pointed out that many limitations within the scope of information offered were related to the emphasis of their school-based sex education on physical safety and the reduction of violence without including information on the emotions and psychological wellness involved in understanding and exploring one's own sexuality.

The focus of sex education on sexual health rather than sexual wellbeing perpetuates the aforementioned Western notion of the separation of mind and body as two distinct concepts, and a global tendency for discussions of sexuality and sexual health to only focus on, measure, and discuss the quantifiable aspects of sexual health, such as physical safety and disease prevention, despite the concurrence of psychological and physical experiences of sexuality (Ford et al., 2019; Tuhiwai Smith, 2021). Sexual wellbeing offers a site in which to problematize these longstanding cultural institutions within health as a whole and realign sexuality education with the lived realities of young people, where "psychological safety matters too," and emotions and lived experiences are important learning tools. As Hunt (2022) noted, "students simply wished to be told more about the reality of sex and sexual encounters" (p. 472). Romeo and Kelley (2009) describe sexuality as "an essential part of human development," and beyond sex, "covers a wide range of behaviors, personal expression, and communication" (p. 1001). They point out how sexual development involves significant and varied changes to the human body and, "[a]lthough sexuality education courses may discuss these physical developmental changes with adolescents, they often overlook the ways in which these changes affect interpersonal and cultural experiences throughout young peoples' lives" (p. 1001). In this way, the literature echoes the sentiments of the participants, that sex education taught in a classroom is inherently limited in providing young people with the tools they need to practice sexual wellbeing, because of the

deep-rooted ways students are taught to see, relate to, and understand sexual health, sexuality, sexual development, and the absence of continuity in sex education courses.

Filling in Knowledge Gaps from Media and the Internet

Participants also identified a barrier in the difficulty of finding accurate and helpful information in the absence of relevant information in their sex education classes. Participants had varying perspectives on the helpfulness of the internet in filling in gaps left by the sex education they received. Gabriela described it as a vital tool, noting how, *"The internet was probably how I learned most of the stuff that our curriculum didn't cover."* Helena said that she usually does not use the internet as a resource, because *"Some people like to twist information… and so, I find that to learn it on the Internet isn't… really effective. And for a person who has never talked about it, or doesn't know what masturbation is or sex and they see a video of, you know, sex... that's probably gonna make them freak out… I just find it not very helpful."* Other participants also described stumbling upon other information sources accidentally as their first encounters with sexuality, and the risk of finding inaccurate or incomplete information on sex and sexuality from media or the internet, specifically from pornography. Sam brought up how, *"especially for youth, a lot of times the internet is their sex education before they have it in a formal classroom setting."* Sam also gave an example of this, saying *"The first time I even learned what masturbation was, was from watching a TV show. So… you know, that's also incomplete, and I had all these anxieties like, 'What is this?' 'Is this something you can get addicted to?' 'Is this something that's bad for you?' I really didn't know because, you know, it's a little clip on a TV show, it's not intended to be someone's first exposure to that material."* Participants described how this experience often offered incomplete or confusing information they may or may not have been ready to process. They described how seeing sexuality portrayed for the first time in media can be confusing or misleading in physically and psychologically harmful ways because of key omissions within information not designed to inform but designed for entertainment or pornography. Participants also pointed out that it's difficult to find

resources if you are unsure what to look for or what information you need, and false or harmful information is readily available and marketed as reputable. As Sam acknowledged, *"there are resources online, lots of really great reproductive health places, but, it's hard to know what to look for, especially with crisis pregnancy centers. They're really clever and awful at making it seem like they're a reputable source and then giving you false information."* Further, Gabriela who said that she was able to successfully fill in gaps in sexual knowledge using the internet, also mentioned how her introduction to the internet and social media was a driver of self-esteem and body image issues, as she was subject to widespread societal standards of beauty, attractiveness, and desirability for the first time.

Young peoples' use of the internet to fill gaps left by formal sexual education has been a common topic of research in the last decade or so with the arrival of the ubiquity of smart phone usage. 73% of adolescents aged 13-17 own a smartphone ("American Adolescents' Sources of Sexual Health Information," 2017), and a majority have searched for health information online, particularly, sexual health information (Lindberg et al., 2016; Mitchell et al., 2014). Among LGBTQ+ youth, searching for sexual health information online is even more prevalent. Literature has indicated that this is often because of their lack of access to this information in schools, and feeling like they had nobody to ask (Mitchell et al., 2014). It was also found that rural youth were more likely to say they searched for information online because they had nobody to ask (Mitchell et al., 2014). Thus, the barriers to accessing information identified by participants in this study appear to be more widely prevalent issues. The literature also noted that the internet can play an important role in filling these gaps for youth with lack of alternatives, and can improve knowledge and sexual health outcomes, but also can lead young people astray with misleading or false information, specifically that which is created on purpose to censor sexual and reproductive health information, as Sam mentioned. The Guttmacher Institute reported in 2017 that in an examination of 177 sexual health websites, 46% of those on contraception and 35% of those on abortion contained inaccurate information ("American Adolescents' Sources of Sexual Health Information," 2017).

The participants went into detail when discussing the specific reasons why they weren't able to access relevant information in their formal sex education, both in cases where the participant was able to

attend a class and receive some information, and where the participant wasn't able to fully access the formal sex education which was offered to them. Participants identified barriers to learning in the environments they were coming from, barriers within the limitations or omissions of information in the material being taught in their classes, the classroom environments they were in, and the incompleteness of school-based sex education which doesn't begin when they are young and cannot span into their adulthood. They also described the confusing, unhelpful, and sometimes upsetting experience of learning things they didn't get information on in sex education from TV or the internet, without any guidance or support from which they could get more information or ask questions that arose from seeing such material. Participants offered examples from their own lives which made it clear that these aforementioned fears and feelings of shame, exclusion, and isolation which they named as major barriers tended to be enforced in the school-based sex education they received. Through these testimonies it becomes clear the ways in which inadequate, incomplete, or inaccurate information on sexuality, mostly related to the deficiencies of school-based sex education, can pose a large, multifaceted barrier to sexual wellbeing for young people.

Having Systemically Unequal Access to Wellbeing, Safety, Safe Spaces, Education, and Resources

Another barrier that consistently arose throughout this study was the experiences of participants related to having systemically unequal access to the vital components of sexual wellbeing, including safety, safe spaces, education, and resources. Of the four participants, two identified as having a disability. One identified as heterosexual, one as lesbian, one as pansexual, and one as bisexual. Two participants identified as trans or genderqueer. Two identified as White, and two identified as being Hispanic or mixed race. The identification of participants as having one or more marginalized identities in the demographic questionnaire distributed to participants allowed the experiences they had of unequal treatment in comparison to peers, discrimination, or disproportionate levels of barriers in their lives to be situated within their identities and backgrounds. With this information on each participant's identity, I

was able to analyze the ways in which their identities may have impacted the barriers they faced and the supports they were able to access and consider the contribution of intersectional systemic factors on each participant's perception of - and ability to practice - sexual wellbeing.

Not Being Listened to or Believed – Medical Ableism

One of the experiences of systemic denial of resources experienced by a participant was being denied access to medical care and physical safety. Helena identified as having an intellectual disability. One of the major themes of her testimony was the lamentation that *"no one believed me."* It came up many times, including when she was discussing contraception: *"[the pill] made my period so [much] heavier and I just didn't like it. But at that time, no one believed me…"* as well as when she tried to report the abuse she was experiencing when she had to go to the hospital because of injuries sustained from this domestic violence: *"I told someone about me being pushed down the stairs because I had to go to the hospital. I told the doctor what happened, but again, the doctor didn't believe me. He believed Maria, 'cause she said, 'oh, she just fell. She lost her balance and fell,' like, no, I got pushed. But again, no one believed me."* This participant found that this doctor didn't respect her agency and didn't listen to her when she told him how she sustained her injuries. This participant described how, throughout her life, she was abused, her agency was denied or undermined, or she wasn't listened to, by her guardians, by her peers and teachers at school, and then also by service providers when she tried to access medical care. She described how this experience, having nobody believe her when she tried to access medical care was severely harmful to her overall health, as she continued to be subjected to abuse, and ultimately had large impacts on her mental health, causing feelings of rejection, dehumanization, and isolation. This dismissal from each support system she attempted to access led her to a suicide attempt, after which, she was finally believed. She asserted that this should not be something that anybody has to experience.

This participant's experience is an example of one of the larger barriers to sexual wellbeing of medical discrimination faced by those whose identities are marginalized, or outside of sexual "propriety"

such as somebody with a disability. As mentioned previously, people with disabilities have long been targeted by reproductive oppression as a group not fit for reproduction, and as a subject of eugenics (Ross and Solinger, 2017). Further, people with disabilities are often underserved and denied access to overall healthcare, as they face "patronizing attitudes, minimization of symptoms, and a lack of recognition of their autonomy" (Engleman et al., 2019, p 237). Engleman et al. (2019) note that the medical system sees disability as a "deviance from accepted medical 'norms'... medical professionals are expected and encouraged to intervene and provide rehabilitative and curative services to minimize or lessen the disability," indicating the ways in which people with disabilities may be subject to dehumanization on account of their disabilities from healthcare professionals, including being denied self-determination and seen as "passive recipients of help" (p. 237). This is part of the dichotomy between who is "believed" or not, or taken seriously or not within the medical system, and particularly the sexual and reproductive health system. This participants' testimony, situated within the literature, demonstrates how a young person with disabilities may experience denial of care, services, or resources because of this undermining of agency and credibility across societal institutions.

Unequal Access to the Classroom

One of the major ways in which systemic oppressions posed a barrier to equal access to resources for participants was illustrated in their descriptions of their experiences of exclusion, rejection, harassment, or inequality in their sex education classrooms or in their schools. Gabriela alluded to the way socioeconomic inequality dictates the quality of education in U.S. public schools. As she described: *"Different schools have different curriculums, but then the way that those schools are funded affects those curriculums… And then you get into how funding works…"* meaning one student in one town in Maine may have received an entirely different sex education than a student in the next town, depending on the incomes of those who live there.

Beyond the actual contents of sex education class, those participants who identified as having a disability, and/or being LGBTQ+ reported finding it especially difficult to feel safe and welcome in class because of the lack of acceptance they experienced in their school or community. For example, Sam, who identifies as genderqueer, recalls *"being in middle school and saying that there was more than two genders, like, that non-binary people existed and just getting attacked at all angles, like really bullied for it. And I was not a crier at school, but I went in the bathroom and cried."* He described how this made it difficult for him to participate or engage in sex education class as they did not feel safe enough to speak up. Gabriela who identifies as bisexual also talked about the difficulties in self-acceptance, self-esteem, and practicing sexual wellbeing caused by growing up in an environment that's discriminatory against LGBTQ+ identities: *"...If you're in a community or a school or anywhere that isn't as accepting [of LGBTQ+ individuals]... it just makes it harder to find where you fit in ... and that again, it impacts the way we think about ourselves and automatically makes it harder to take care of ourselves. If you feel bad about yourself then it's gonna make it 10 times harder to take care of yourself in the way that you need to be taken care of."* Helena, who self-identified as a person with a disability, described being treated unequally in her sex education classroom: *"In high school the teacher talked fast. He didn't pause. And when I tried to ask a question, he didn't [call on] me, so I just felt excluded, because he asked other students, but he didn't ask me."* All participants talked about the harm these experiences caused to their self-perception, self-esteem, and sense of belonging.

The impacts that these participants describe illustrate how even when a young person is able to access sex education and finds themself in a sex education classroom, even one where vital information is offered, they may find that they are still unable to learn, ask questions, or gain relevant knowledge because they may feel unsafe, be denied the space to speak, or otherwise feel that they do not belong because of their identity and how it may set them apart from their peers. Sex education being an uncomfortable experience and classrooms being places where students did not feel safe or comfortable to talk about or learn about sexuality was something participants noted was common among their peers, aligning with the literature on the sex negative norms of society as a whole, the particular stigmatization

and vilifying of youth sexuality, and the reproduction of these norms in sex education policy, curriculum, and mandated teachings. However, they also made it clear that the experiences of these norms are different and compounded among those with adverse life experiences, such as domestic or sexual violence, and those with identities with unequal access to schools, to healthcare, to classrooms, and to safety wherever they go.

Experiencing Particular Silence, Shame, Discrimination, and Violence Surrounding Sexually Oppressed Identities

Participants described either experiencing or witnessing homophobia or transphobia and the way it impacted them or their friends as queer people. One of the ways participants described homophobia/transphobia as manifesting was the compulsory silence surrounding being LGBTQ+ in an unaccepting environment. Participants described the unique discrimination faced by queer people in that their marginalized identities are not usually visible or apparent to others, so a part of the harm of the unequal treatment they face is feeling as though they must hide their true identity to protect their safety and maintain relationships with those who may not be accepting. Sam describes how this can pose a barrier to sexual wellbeing, and prevented another student at their college from access to LGBTQ+ safe housing: *"I'm thinking about queer people who maybe aren't out, wanting to be in their GSA, or... I know someone who wanted to live in my theme [Sexuality Affirmation and Freedom of Expression] house, but she didn't want her parents to find out that she was living here... that can definitely be a barrier."* Participants described having a difficult time feeling comfortable and safe enough to 'come out' and be their authentic selves, and recounted seeing others struggle with this as well, especially in situations where it was unsafe to be LGBTQ+. For example, Gale who identified as trans and pansexual described the danger he was in for even mentioning a trans person's name in his house: *"I accidentally called them [their chosen name] once and my stepdad was on the porch with me... he broke my laptop … and said he was gonna kill every trans person... he went on a tangent, a drunk tangent, and said he was gonna kill*

*me... threatened to shoot up the mall because he had heard that I was gonna potentially be at the mall. He was like, 'well all those f*****s are at the mall either way, so I'm gonna shoot it up.' A whole situation. He got arrested. Got my pellet gun taken because of him."* Gale went on to describe how this impacted him, saying, *"It was an unsafe situation to even talk about that kind of stuff in my household... the gays and lesbians were okay, but everyone else was sin, you know? ...talking to my friend about possibly being trans in that timeframe, it was just really hard 'cause that was right before I came out."* This restriction of self-expression, and queer identifying participants' knowledge that their communities or families may not be accepting of their true selves was described as a large barrier to their access to resources, safe spaces, or interpersonal support. Participants described instances where they or LGBTQ+ friends were living in fear that their identity would be revealed to those who would reject them or cause them harm.

In this way, participants made it clear that feelings of discomfort or fear of speaking caused by silence and stigma surrounding sexuality were experienced differently among the participants and not equally distributed across youth populations. The participants faced disproportionate access to safe spaces, with higher likelihoods of being denied safe spaces in their homes, not being able to access safe spaces others could, and being subjected to discrimination, denial of resources, and violence. The experiences of transphobia, homophobia, and ableism recounted by the participants reflect broader trends in the U.S. Just as Helena discussed feeling excluded and not being able to engage with the sex education they received, Kattari (2023), discusses how young people with disabilities are especially and continuously left out of sexual health education and often do not see it as pertaining to them. Stemming from the aforementioned ideas of young people with disabilities as nonsexual, disabled youth are less likely than their non-disabled peers, and individuals with intellectual disabilities are even less likely (25%) to receive comprehensive and effective sex education than other disabled youth (47.5%) often because they are removed from the class during sex education or taught separately altogether (p. 84). Further, those with disabilities face highest instances of violence, as well as steeper health, financial, and social consequences of violence, than those who do not have disabilities. Particularly, those with

intellectual disabilities experience 7 times higher rates of sexual assault than those without disabilities, and women with intellectual disabilities experience 12 times the rate of sexual assault than those with other disabilities (84). This violence is also underreported, as methods of reporting may be inaccessible or those with disabilities may be reluctant to report for a variety of reasons, including, as described by Helena, not being believed (Katari, 2024). In this way, people with disabilities face particular exclusions, discrimination, and barriers to their ability to practice sexual wellbeing, and are likely to experience sexual wellbeing in a different way that nondisabled peers.

Those participants who identified as being LGBTQ+ cited feeling especially confused, isolated, frustrated, and unable to speak out because of their feelings of sexuality and the recognition that their experiences of these feelings were different from their peers. Some experienced harassment, violence, and homelessness as a result of their queer identities. These experiences again reflect larger trends of discrimination and oppression in the U.S. Although making up only 7% of the youth population, queer and trans youth, and disproportionately queer and trans youth of color comprise almost half of all youth experiencing homelessness in the U.S.; family rejection, discrimination, and violence are named as root causes of this disparity (Ritholtz, 2023). Queer and trans youth experiencing homelessness are further subjected to higher rates of depression, suicide, substance abuse, sexual and physical violence, discrimination, and HIV than cis and straight homeless youth, and housed queer and trans youth (Ritholtz, 2023). Aside from the denial of safe spaces and resources, queer and trans youth face disproportionate mental health burdens associated with discrimination, as queer youth are five times more likely to attempt suicide than straight youth, and over 40% of trans Americans have attempted suicide (Ritholtz, 2023). Further, the threat of physical violence against queer and trans people in the U.S. is growing. While 79% of straight and cis Americans support equal rights got LGBTQ+ people, the instance of hate crimes reported by queer and trans people has risen steadily since 2015 (Ritholtz, 2023). In this way, participants illustrated the compounding barriers that accompany being denied access to adequate sex education, as inadequate sex education often comes with harmful exclusions or explicitly discriminatory messages,

perpetuating the shame and isolation felt by and possibly violence against those outside of accepted societal standards of sex and reproduction, particularly those with disabilities or LGBTQ+ students.

Intersectional, Identity-Based Exclusion

Another common experience of participants was not being able to access the identity-specific support, safe spaces, resources, or care they needed because of their intersectional identities, and the increased difficulty of finding intersectional safe spaces or resources for those of multiple marginalized identities. Participants particularly described the exclusion of people of color and people with disabilities who also have other marginalized identities from resources, safe spaces, support, and information. For example, Gabriela discussed how, *"when we're kind of looking at Feminism and sexuality from a very white perspective... it can just, make it feel isolating… for me, that's one of the barriers I feel."* Sam echoed this idea, saying *"you might not feel fully welcomed or included in a space… maybe if you're like a person of color, you might feel excluded from certain LGBT spaces, or women's spaces... a criticism that I hear a lot about, my school's Feminist Association is that it's all white students and that people of color don't necessarily always feel like they have a voice there."* They emphasized the way this prevented those who face intersectional oppression from seeing these spaces as safe spaces, posing an additional barrier to queer people of color, who may be seeking a safe space where they feel their LGBTQ+ identity is accepted and they can connect with others, only to find nobody who looks like them or shares their experiences in those spaces.

Participants also alluded to how these intersectional barriers can escape the notice of those creating and occupying safe spaces because of a lack of space made for identities other than the dominant ones within the space. As Sam noted, *"All the time, like places that really pride themselves on being inclusive are sometimes still missing, like a big part of the population… If you feel like you're including everyone, there's a lot of times, still a voice that you don't even know you're not including because that voice isn't in the conversation."* What participants are describing has also been mentioned in the literature. For example, in spaces where whiteness is made invisible as a norm, which can create spaces

such as LGBTQ+ or feminist spaces which are then dominated by white voices and white perspectives which make them white spaces, where queer people of color or women of color don't see themselves represented or feel as though their voices will be heard. For example, Morgensen (2010) discusses the normative whiteness within national queer movements in the U.S., and how, as they have sought recognition under the settler-colonial nation-state, they have fought for the acceptance of white queerness. This acceptance occurs under the conditions of accepting the nation-state's rule of governance and perpetuating the destruction of Indigenous identities and history, by claiming white queer identities as native to the land (Morgensen, 2010). Thus, queer spaces are often critiqued for their whiteness and blindness to nonwhite queer identities, and resultant exclusion of Black, Indigenous, and nonwhite LGBTQ+ individuals. In this way, intersectional exclusion is often made invisible to those facing one marginalization, as one oppressed identity cannot be understood without considerations of others. As Ross writes, "neither race nor gender by itself could capture the particular experiences of Black women" (73). Arvin et al. (2014) quote Audre Lorde (2007, p. 138), in saying "There is no such thing as a single-issue struggle, because we do not live single-issue lives" (p. 18). This is something personally understood by the participants.

Sam discussed how spaces which are not accessible or inclusive of people with disabilities pose a barrier to those looking for safe spaces. They described an example where, at their college, there is housing dedicated specifically to be a safe, queer space for LGBTQ+ students, but that often, LGBTQ+ people who have disabilities or require other accommodations to access the space, are simply not able to. The participant points out that this house which is considered safe space for queer students is really only a safe space for able-bodied queer people, because of a lack of accessibility for those with disabilities. Kattari (2023) highlights this lack of LGBTQ+ discussions within disability focused spaces, and a lack of accessibility considerations in queer spaces for those with disabilities, despite that LGBTQ+ individuals are more likely to identify as having a disability than cis or hetero people in the U.S. (p. 299). The barriers which youth with disabilities already face in accessing safe spaces and acceptance for their sexuality are then compounded for queer youth with disabilities.

Participants also highlighted the economic barriers and class discrimination which prevent young people from accessing safe spaces and the interpersonal support, resources, and information that come from them. Gabriela described the difficulty of feeling like you don't belong in your community or have an identity different than the mainstream, and how, under those circumstances it takes additional effort to be able to seek out a safe space: *"I'm someone who can very much self-isolate and... I find it a lot harder... to kind of go out of my comfort zone and when I do that I kind of shut down. So sometimes it takes effort to kind of go out into those spaces... And then…those feelings can be made worse when we're kind of in a situation where... other people have a very different socioeconomic status than my own."* She illustrated how these feelings of isolation and exclusion are exacerbated and compounded when the safe spaces she finds may be excluding of another aspect of her identity or experience, in particular, socioeconomic status. Sam also pointed this out, noting how many safe spaces found by the participants were in their communities, not affiliated with their school, and were things that each of them had to seek out, emphasizing that *"there are economic barriers... if you're a high school student who needs to work and help support your family and pay bills, then you might not have the time to go to an after school, club or organization."* Gale told the story of his friend who is transgender and did not have an accepting community, and also couldn't afford to access gender affirming care or resources: *"I had to tell them [my friend]'s dead name because they couldn't afford a binder and their family wasn't accepting either. So when they met [my friend], they... would use the wrong pronouns. And so every time I was on phone with them I was like, 'Hey, I'm really sorry, but you know the drill... I can't call you that here.' And they were understanding 'cause they knew that, you know, what can you do?"* In this testimony Gale illustrates how this friend wouldn't be able to be perceived in their community as their identity, or 'pass' and instead had to accept that they would be misgendered, or called by the wrong pronouns and wrong name, which can increase feelings of distress and gender dysphoria. Financial and socioeconomic barriers proved to be major obstacles for participants in being able to access resources, and especially identity-specific resources, which are often not viewed as major needs of young people, so would not be offered at their schools.

Section 3: Supports of Sexual Wellbeing

As we move into our discussion of the sexual wellbeing supports accessed by these four individuals, it's helpful to look back at the elements they described as being vital to sexual wellbeing, and how they defined sexual wellbeing. They discussed sexual wellbeing as the lifelong process of exploring, learning, and caring for oneself in terms of sexuality, whatever that may mean for each of us. Practicing sexual wellbeing is inherently a subjective and individual thing, as they understand it, and their narratives reflected this, as it looked very different for each of them. However, there were common elements which each of them identified as more widely applicable to sexual wellbeing across individuals and groups. These are: access to resources, access to education/information, access to interpersonal support, and access to a safe space to be themselves. The supports I have identified in the participants' testimonies and laid out in this section are those tools, resources, learning experiences, and care from others which have helped each participant to realize sexual wellbeing for themselves, supporting them in one or more of the aforementioned areas of sexual wellbeing they brought to light. The resilience, resourcefulness, and strength of these young people in reaching out, seeking, and finding supports, even when they found themselves in situations where they were not readily available to them, as well as their drive to then channel these supports into supports for others, is a remarkable center point of these research findings.

Community-Based Organizations as Hubs of Sexual Wellbeing

Youth and Identity-specific Programming, Particularly Related to Sexuality and Sexual Health

Despite the variance among participants experiences and sexual wellbeing needs, they all described how when they found themselves lacking information, support, or resources from their schools, communities, or families, community-based organizations and those who work for them played instrumental roles in fulfilling these unmet needs. Maine community-based organizations, such as

Planned Parenthood, Hardy Girls Healthy Women, Maine Boys to Men, and New Beginnings were repeatedly brought up as key supports in allowing participants to access sexual health learning experiences and sex education, as well as resources, interpersonal support, and safe spaces.

In nearly all participants' testimonies, the major supporting factor that led them to these organizations was programming geared specifically towards youth or their identity. For two participants, they found these programs through other similar programs in their schools. Sam describes how his lack of information drove her to seek out discussions on sexuality, *"I remember being in high school, being so anxious that like, I'm gonna lose my virginity and not know it because I don't know what sex means for me as a lesbian. So that was when I got involved with Planned Parenthood's Peer Education Program and it sort of like took off from there."* Gabriela recalled how, *"shame is something I've struggled with, and as I've kind of gotten older [I've] found different, like places and organizations that helped me like kinda learn and tackle that, like with Hardy Girls and the different programs that I've been a part of with them and just like finding people has been so great and helped me learn so much about myself."* However, the two participants who had difficulty engaging at school because of instability in their home lives accessed community-based sexual health programming through other sources of support related to their home situation, such as at the shelter, or through case managers. These were important sources of support who connected them with identity-specific resources. In Helena's case, a key resource was a healthy relationships class geared towards those with disabilities. As she remembers, *"It wasn't until after high school… I was still… not in a great space... it wasn't until after like longer, I took a sex ed class and, um, I'm like, oh wow, okay... there's more than just having sex? That just… stunned me."* Gale described how he found his way to the New Beginnings shelter - which became a hub of support for him - simply because it was the closest one to him at his time of need: *"My mom... said, 'coming back isn't an option, so what do you want to do? Do you have any other friends you can go to, like anywhere else you can go?' And I was like, 'I don't have anyone.' And so she looked up homeless shelters and she dropped me off in Lewiston at the homeless shelter on the same night."*

The two participants who self-identified as having disabilities were also the two who described growing up in unstable or unsafe home environments. For these two participants, having access to education which accounted for their specific identities and experiences was particularly vital, as was being able to go through this learning with an instructor with whom they already had a connection to or relationship with, and who could give them a lot of one-on-one interaction. These relationships enabled them to learn at their own pace and ask questions along the way. Gale discussed how he was finally able to access sex education in this setting: *"I think differently than everyone else… I have a processing syndrome, so I've been put under autism... everything's backwards up there. Just learning about everything and having someone sit down from New Beginnings and just actually teach me about it and just understanding myself more and… knowledge is power."* He also noted the importance of having his instructor be available to him regularly, even as he was experiencing homelessness: *"Having the sex ed teacher at outreach has been a really helpful tool for me… being able to talk to her whenever we need something, or if we have questions about anything and just being in her trainings..."* Helena also described accessing sex education through somebody with whom she has a personal connection: *"My former case manager… had a 'healthy relationships' class. It was... a 6 week class... I went every time and I learned a lot… [about] the birth control. That just blew my mind 'cause I didn't know, 'cause I only thought there was one. So when I learned about them all, I'm like, 'oh my gosh.'"* Helena described what drove her to attend this class and what about it allowed her to learn in this setting: *"One thing that made me feel comfortable was, I already knew [the instructor], and so it was helpful to have someone I knew... I was able to ask my questions and like, [the instructors] were patient with me. Because I do have a stutter, so sometimes it just takes me longer and not all people actually stop and pay attention to me. So it just felt nice to have that... And in high school it was so loud. And the class I took, it was nice, it was quiet."* This testimony provides stark contrast with her experience of school-based sexuality education and indicates how meeting identity-specific needs and accommodations is vital to providing adequate education in safe spaces of learning.

These participant's testimonies highlight the importance of having access to these supports within their neighborhoods, schools, or other community institutions. As Gale said of sexuality education, "*I didn't really learn about any of it until I became homeless when I was like 13, 14."* As counterintuitive as this quote sounds, it follows the patterns experienced by other participants, that when mainstream supports, which are said to provide the tools needed to practice sexual wellbeing, i.e. families, schools, formal sex education, healthcare providers, etc., failed these young people, community-based care organizations provided vital avenues of support which they would not have been able to access otherwise. This access to community-based care in the failure of mainstream and public avenues of protection and service is a common theme throughout an RJ analysis of history. Ross and Solinger (2017) emphasize the role of community health centers in offering resources to populations underserved by state institutions, and reference community organizing, information, and resource sharing as methods through which those under reproductive oppression have claimed their autonomy.

Community Organizations as Safe Spaces to Be

Participants described the importance of having a space outside of their homes and schools, especially if these are places where they did not feel safety or belonging, which they could consistently go to and feel comfortable, known, welcomed, accepted, and cared for. Participants described community organizations as the places where they most readily found these spaces. For Helena, this was "*...Planned Parenthood, that's like the space I feel comfortable in, and like that's where I feel like no one judges me.*" She also mentioned how important the Planned Parenthood of Northern New England (PPNNE) Disability Community Advisory Board Committee was to her as a space to talk about sex and sexuality, and where she felt respected and listened to. Gabriela also described finding these feelings of respect and acceptance, through *"Hardy girls, and different organizations like it. Whose entire goal was... to create these spaces, for girls and gender expensive youth who have been denied these spaces and experiences in the past."* For Gale, who had also been systematically denied safety and experienced violence throughout

his life, the New Beginnings shelter became a safe space where he felt he wasn't judged. He illustrated the huge impact this had: *"there is a back patio area where... since 13... that was my space to go smoke a cigarette… they don't judge and they'll come out, talk to you while you smoke a cigarette and they don't judge you. And if you come in drunk or you know, smoking weed... that's what I did. I smoked weed. And, um, and if you came in like that, they didn't judge you."* He also discussed how this space allowed him to feel safe to be authentically himself: *"I came out at the shelter. I was like, you know what? This is who I feel, I'm confident that I am. I had the space to be me finally… and the acceptance to be me. So it was nice."* He also emphasized how much he loved the youth-centered design of the shelter, giving young people facing instability in their lives a place they can still go to play and be a kid: *"I love it because, they built the space to be so youthful in mind... when you walk in on your left, there's a big pool table… there's couches, there's tv, so you can watch whatever you want on Netflix or Hulu. You can listen to music... there's a little fish tank in there, there's a music room, there's puzzles, there's things to do with other people or do by yourself."* Gabriela also emphasized the importance of having a physically comfortable space as a safe space. Participants mentioned how these spaces were safe spaces where they felt that their identity was accepted, respected, and valued, and as young people who experienced marginalization due to their identities, they enjoyed these spaces because they felt like *their* spaces.

Resources and Services offered Holistically, Confidentially, without Judgement and without Undermining Agency

Another major support identified by Gale, was the way the services were offered at the New Beginnings shelter, which made the resources accessible to him and others who may be isolated and alone otherwise. He repeatedly mentioned the no judgement policy of the shelter, especially relating to things such as substance abuse and sexual and gender-based healthcare: *"They'll do... outreach where they'll go walk with backpacks... around town handout condoms, handout safe injection kits and cleaning kits... so if you're using, you're using clean… you're allowed to go in there drunk... you're allowed to go in there high... As long as you're not being... dangerous towards others or yourself, or the space.... as long as*

you're also not using on property... Even if you were doing some... harder stuff. They still didn't judge you, which was nice. 'cause then you still get that good community through hard times until you're ready to, you know, quit or stop whatever you're doing…you know you have the resources to do it whenever you want... or not and still have the support and safe, clean, space to be while you're doing it... 'cause they also hand out Narcan... I have Narcan. And they... offer Narcan trainings and… usually like there's a little paper you have to fill out for the Narcan. They generally ask you like, 'you don't have to answer, but like, why would you like Narcan?' and that information only stays with them just in case, you know, anything ever happens, they know... 'I need Narcan for myself because, you know, maybe I do harder stuff.' And they're like, 'okay, bet. Here's Narcan. Stay safe. Make sure that if you do something, you do it with a friend - buddy system.' And they'll... give you tips. Like if you explain what's going on, they'll give you tips about your situation, how to help, when, you know, most people would do it alone." He described how he also got access to food and other supplies and services: *"They feed you. They make sure you have water. If you don't want a food box, they'll fill your backpack with food and water... There's a community closet where they have... feminine and masculine sides, so you can pick whatever you want on each side. No judgment. You're allowed to close the door if you want to secretly throw some clothes in your backpack without everyone seeing... if you are homeless, they have tents and sleeping bags... and blankets and stuff ready for you... And they were able to offer a shit ton of services. I was in and outta the shelter... they have case managers... they have like a whole team there… the ED center upstairs, they help with... education for anyone, like of all ages... free Wi-Fi 24/7... when I was homeless... me and my friends would go there, connect to Wi-Fi..."*

Gale noted how material resources, vital health services, as well as education, housing, and interpersonal support were available to him and all those who access the shelter in a non-prescriptive, no-strings-attached way, which centered the agency of those accessing them. There were little to no prerequisites to accessing the shelter and the services offered there, and there was no requirements or lifestyle changes needed to continue to receive services, even among those living outside the shelter, those who have addiction, or are using drugs. The no-judgement policy of the shelter described by the

participant enables each person needing help to be welcomed as they are and be met where they're at. The participant also noted how the way these services were offered made space for the humanity of other drug users and allowed for others using drugs to still be able to access care and support through addiction, giving them the resources to stop using, and the support to be safe until they did. One of the other major supports which made the resources offered by community organizations accessible to participants was privacy and confidentiality within the services offered to youth. This is especially true for LGBTQ+ youth for whom it may be unsafe to have their identity revealed or be seen accessing services by family or community members. It can be vital that services be accessible without the permission of a parent or guardian.

Another notable aspect of Gale's testimony on the resources he was able to access at the shelter was their holistic quality. He made it clear that resources or supports which only address a partiality of one person's wellbeing or health cannot allow a person to overcome barriers they face. He described being able to access a myriad of support and services there that he urgently needed to meet the basic requirements of survival, like shelter, food, and clothing, but also services that aren't typically associated with shelters, like confidential sexual health support, including sex education. The way these services were offered reflected a deviation from the social and moral stigma of homelessness, and criminalization of unhoused populations (Elliot 2014). The shelter offered services in a way that considered the myriad of ways a person may find themself experiencing homelessness, with an implicit understanding of the intertwining of physical, mental, and emotional needs of those experiencing homelessness, going beyond providing access to basic food and shelter. The participant emphasized multiple times the significant impact these resources had on the ability of struggling community members to access help.

The privacy, confidentiality, and policy of no-judgement of the shelter, their offering of all of these vital services, from gender affirming clothing to substance abuse services, to education - in the same place, created a space where, after not being able to have access to stable shelter or support growing up, this participant was finally able to feel safe and comfortable enough to access the help he needed, and have it readily available to him. Ross and Solinger (2017), also emphasize the necessity of using of a

holistic lens within RJ care, pointing out that a non-holistic view of ones' care is likely to leave the root cause of a persons' suffering unaddressed. This understanding, put into practice in the offering of services at New Beginnings, that sexual health is a key piece of overall wellbeing, just like food, clothing, and shelter was a huge support for this participant, and reflected the conceptualization of sexual wellbeing by all participants as a vital piece of overall wellbeing.

This ability of community-based organizations to provide services unavailable to youth elsewhere was also noted in the literature. Fisher et al. (2012), noted that in Indiana, community-based organizations, rather than schools, were where young people were accessing sexual health information, and young people discussed receiving information on sexuality which was accurate, accessible, and holistic, meaning community organizations were able to offer information, as well as referrals, resources, services, and/or programming related to the young person's needs. The authors point to a similar outcome in the efficacy of community-based organizations in being able to provide a quality of sexuality education schools could not because of limitations and scrutiny within public school systems that the programming of community organizations is not subject to in the same way (Fisher et al., 2012). This indicates that the findings in this study on community-based organizations as sources of sexual wellbeing support in Maine could also potentially hold true in other states and contexts.

Participants indicated the many ways in which community-based organizations hold norms within their policies, programming, and services which deviate from the oppressive societal standards which the young people encountered in their schools, homes, and elsewhere in their communities. The disruption of these norms is made possible because of the separation of these organizations from state structures of governance, therefore allowing them to deviate from state control and suppression of knowledge on sexuality noted in the disparate offerings of material, funding, and political support for effective content across the public schools of the country (Elliot, 2014; Clark and Stitzlein, 2016). While many of these organizations are publicly funded, they are often given discretion, depending on the current political will, in how they use these funds. For example, the funding for this research project, all of which was given to participants as stipends, was from a federal grant for the prevention of STIs directed to Maine Family

Planning. When these organizations make decisions and adopt policies to create spaces of subversive norms, young people's sexual wellbeing can benefit.

Effective, Accessible, Accepting Safe Spaces of Learning

While each of the study participants indicated that they did receive formal sex education in their school experiences, they also made it clear that they considered this education inadequate for equipping them with the knowledge needed to practice sexual wellbeing. In some cases, their experiences with sex education elicited feelings of exclusion, otherness, isolation, confusion, and anxiety, because of glaring omissions in curriculum, uncomfortable classroom environments, and underlying messages of shame surrounding youth sexuality. As a result, participants were left without the information on human sexuality that they wanted and needed, and for some participants, what followed was the realization that they would have to look elsewhere to get their sexual health questions answered. Each participant described in depth how they found educational supports along the way, outside of formal school-based sex education, within their communities. They also described what differed about this education from the course they received in school, and why it resonated with them and allowed them to gain knowledge when the school-based education they received had not.

A Safe Space to Learn

While participants noted how community organizations offered them safe spaces to be, they also pointed out that in order to learn, they needed to feel safe in spaces they felt they wouldn't face judgement, discrimination, or harassment from others. Sam remembered how after experiencing bullying in school for talking about the existence of nonbinary people, something which allowed them to feel safe was *"having that safety aspect of knowing the kids who think and act like that are not in this space… that definitely made it feel safer to be vulnerable."* For Helena, her healthy relationships class at Woodfords

Family Services specifically geared towards individuals with disabilities offered this space. As she described: *"What I liked about that class is, no one judged me, or made fun of me… Because in high school I was made fun of a lot."* For the participants, their sexual health learning experiences took place at the intersection of having a safe space to be, and having relevant information or interpersonal support available in that space. Some also noted that they were only able to learn once they were able to be in a space where they had interpersonal support and relevant information, as well as accommodations for their disability.

Gabriela emphasized the role of the internet in giving her a safe "space" to learn, which wasn't a physical space, but an online space where she could listen to the lived experiences of others and gain information through social media. She described how she found this space on TikTok: *"Seeing different people talk about these things in a way that I never had before… I feel like… because you're not really talking to someone face to face… that's why people were able to… talk about some of the stuff that they were talking about and why I was also able to learn from it too, because, you know, when you're face to face having these conversations and… if you don't really know people that well... it makes it harder to fully, kind of grasp in... I did learn like a lot of that stuff through… saying 'conversations' with quotation marks, but like just kind of hearing other people talk about it and just kind of feeling like it was kind of a conversation that we were having even though it was through a screen and we weren't talking to each other. But yeah… It was funky."* She felt that, although this is not everybody's experience, her algorithm on social media sites such as TikTok tailored the information to her in a way that made it easier to engage with. She acknowledged that not having face-to-face conversations did pose a barrier to being able to truly connect with the people she was learning from online, but also how it created a space for her where she felt safe and comfortable receiving the information. As she described, *"it definitely started that process and if I wasn't necessarily comfortable talking about it with other people, it made me more comfortable thinking about it and... processing it in a way that, I couldn't do in a classroom setting or something like that, and it felt a little bit more personal than a classroom setting too, you know, ...because it was just me, alone... listening to these people talk and kind of processing that and figuring out what that*

means to me." She described how not having these conversations in-person, or in a classroom setting, allowed her to engage with the information without fearing the judgement of others, and gave her the space to process it and self-reflect on her own time, without the pressures of peers, instructors, or a school environment. In discussing young peoples' use of the internet as a learning tool, the literature tended to focus on this "space" the participant describes as simply a way of seeking privacy or anonymity in asking personal or embarrassing questions (Mitchell et al., 2014). This participants' description of their experience adds depth to this idea of young people using the internet for "privacy" reasons, indicating that in some cases, seeking privacy has more to do with feelings of safety than secrecy.

Including Emotions, Self-Reflection, and Diverse Lived Experience in Sex Education Content

Participants identified the lack of discussion of emotion in their formal sex education classes as one of the barriers to learning. They also described the education they received at a community-based organization to be particularly effective because it included emotions, self-reflection, and diverse experiences of gender and sexuality. Gale describes one such lesson he received at New Beginnings: *"In their trainings, they don't just talk about the facts, they talk about what feelings might come with it and emotions you might feel going through different things. I know that specifically, we had talked about the AIDS epidemic and… one of the justice presentations… talked about the facts, but also with the facts, how the families felt… we watched this video on YouTube about people who had AIDS, who came out to their friends and families and... talking about how they felt about it... learning that you're accepted was a huge, good thing."* This testimony highlights the importance of showing the lived realities of others navigating sexual wellbeing, finding interpersonal support, and struggling with self-acceptance; common experiences which resonated with this young person exploring his sexuality. Sam remembered being a part of an advocacy group and receiving training where he learned about sex and gender: *"Maine Boys to Men, does trainings at [my high school] and a bunch of other high schools… and so we got to leave school for two days and go to town hall and do this workshop... I think the first thing that really stood out*

to me was the gender box activity and the genderbread person... which as a little queer person who didn't really know it yet, that was also, oh my, yeah. That was the first time I learned that romantic and sexual attraction can be separated…that was my first moment of realizing that gender and sexuality could be more complex than just the binary." This exercise in self-reflection which inherently included the diversity of gender and sexuality allowed her to examine their own feelings and lived experiences related to their own sexuality, and created an environment where this participant could begin to see what sexuality means in relation to themselves and begin to address the confusion and anxiety they felt after not receiving this opportunity to learn in their sex education class.

Guthrie (2016) discusses the importance of including emotional knowledges in education, such as lived experience and emotional inquiry, and builds on Million's Felt theory (2009), which challenges the Western notion of the separation of emotion and knowledge in learning. Guthrie (2016) advocates for pedagogical approaches which ask students to use emotional inquiry to build relationships between themselves and the topics they learn about. The importance of seeing lived experiences which included the realities of human sexuality and gender diversity was emphasized by LGBTQ+ participants who had difficulty seeing themselves and their experiences reflected in their school-based sex education classes. This representation was instrumental in them being able to engage with the material presented and address anxieties they felt about not fitting in or belonging in their communities. This experience of participants also mirrors literature which points out the merits of including lived experience in sexuality education, and the significantly higher impact which education through storytelling had on young peoples' ability to gain knowledge than fact-based intervention (Kteily-Hawa et al., 2020).

Shifting Attitudes Surrounding Youth Sexuality Education - Beyond Prevention towards Normalcy

One major support within the effective and safe spaces of learning accessed by participants was that, contrasting with school-based sex education courses, youth sexuality was treated as something important, but not something risky, serious, or uncomfortable to discuss. Rather, it was brought up as something that everyone experiences, that can be casually talked about in a fun way. Participants

described these learning environments as places *"for everyone"* where facilitators are open, and they felt like they could "*ask any questions.*" They mentioned learning sexual health knowledge through playing games, such as sex trivia and Kahoot, and receiving prizes. In some cases, these learning opportunities weren't just for youth. Sam recalled an instance where their local library facilitated a learning session on LGBTQ+ identities for parents and community members: *"I think sort of an unexpected resource for sexual health or self-expression is libraries. I was thinking about my Public Library, growing up, near my school. It had so many amazing programs, like a Teen Advisory Council that helped the Librarians do programming for youth, and one of the things to come from that was… they requested a workshop for parents of queer youth.... I was a senior in high school at the time and I got to come in and do a lesson for the parents of the people on the Teen Advisory Council and anyone in the community who wanted to come."* Sam noted how when students at her college participate in the events put on by their sexual health advocacy group, *"it's fun… they're secretly learning. They don't think they're learning, but they are!"* This can be contrasted with the way participants and young people in the literature described feeling ashamed or fearful in school-based sex education, where the environment is one where it often doesn't feel safe to be curious and ask questions, let alone have fun talking about youth sexuality.

Sam went on to discuss how an emphasis on sex neutrality made the spaces they were in welcoming and effective spaces of learning. In their words: *"I feel like for a long time in sex conversations, positivity was the gold standard. That you have to be positive when talking about sex, but I think that not everyone has all positive experiences… And you know, there are also sex neutral, asexual people. So sometimes it's OK to just be neutral in conversations about sex, and not talk about it as a good or bad thing, just as a part of human experience."* They also spoke to the difficulties educators face in school-based sex education class, when instructors who don't want to stigmatize sex for youth must juggle pressures to prevent teens from engaging in sexuality activity, and community perceptions of sex positivity, which can be seen as encouraging young people to engage in sexual activity. As Sam described: *"I think that it's really important in sex education spaces because, I remember my high school health teacher saying that she wasn't allowed in the curriculum to go into certain details and specifics,*

and something that she was required to say is abstinence is the only 100% effective form of birth control and STD protection... I think that being in a place where we neither condemn sex, nor, I don't think it's always appropriate... in an educational setting, to be overly hyping it up as this awesome thing, which it can be for some people, but that's just not everyone's experience." While much of the literature on sexual wellbeing and critiques on CSE does indeed tout sex positivity as the "gold standard" of discussions on sexuality, participants' testimonies add nuance to this discussion (Goldfarb and Lieberman 2021; Hunt, 2022; Mitchell et al., 2021). They found it most helpful when sexuality was normalized, talked about "*just as a part of human experience"*, rather than from a sex-negative perspective, exemplified by the abstinence focus in their health class, or sex positive perspective, as they point out that limiting the conversation to positive sexual experiences also doesn't portray an accurate depiction of young peoples lived realities. Further, sex positivity may exclude those with negative, traumatic, or complex experiences surrounding sex or those who identify as asexual. This idea of sex neutrality, or sex normalcy, as Sam said, can make it so *"everyone can enjoy those conversations no matter how they feel about their own like sexual history."*

This notion also meshes well with RJ understandings of sexuality, which emphasize the importance within sexual and reproductive justice of understanding of the traumatic histories Black, Indigenous, People of Color, people with disabilities, and LGBTQ+ people have had with reproductive and sexual health and healthcare systems, as well as the lasting impacts of generational trauma. Sex neutrality could potentially offer a way to discuss sexual health and wellbeing while considering the psychological safety of those who may have experiences of medical discrimination, forced sterilization, and other coercive reproductive or sexual practices which still occur (Kattari, 2023; Ross and Solinger, 2017). This idea of normalizing sex, rather than valorizing it also can be situated within Indigenous understandings of queerness described by Simpson (2017), which emphasize normalcy, rather than distinction for queer people. Simpson advocates for implicit acceptance of queerness and sexual "deviancy" as simply the realities of sexuality, in order to oppose the naturalization of heteropatriarchy.

Formal and Informal Peer-Peer Networks

Friends and Friend Groups

Another major support identified in participants' narratives was peer networks: both formal and informal. Instances where informal peer networks served as a support occurred among participants' friend groups, as well as classmates at school. Gabriela emphasized the role of her friend group in providing a safe space and interpersonal support for her. She also went on to describe how just being able to be in groups of peers where she could form connections and find interpersonal support, unrelated to sexuality, allowed her to build peer networks she could discuss sexuality with: *"I definitely sought out groups… it wasn't necessarily intentional, a lot of the groups were... focused on other things, but in those other things, we found solidarity and that made us understanding and kind of connected. And I think that kind of allowed for these conversations to happen. So I think it was just kind of subconsciously, knowing what I felt comfortable with... allowed me to find these groups of people."* She also pointed out the self-discovery and self-knowledge that was required to find these groups, alluding to the interconnectedness of all aspects of sexual wellbeing.

Gale described a formative learning experience of first hearing the term "LGBTQ" and discovering what being trans was from a friend at school: *"In the way beginning of ninth grade… [my friend] was a new student to our school…[they] kind of taught me about like, the L G B T Q community and then I found out, um, my other friends were part of it, but just didn't know if I was."* For him, learning about the LGBTQ+ community was the first step to getting to know himself, and being able to find community. This learning took place in a simple conversation in school between two ninth grade students. He identified this conversation as a turning point that allowed him to connect with his peers and begin to learn more about himself and his identity, taking the first step to being able to practice sexual wellbeing.

This testimony demonstrates the power of peer-to-peer outreach among young people, even in connections as simple as a conversation between two students in the hallways at school. In this way, the

participant was drawn into a peer network of support and information surrounding sexuality, something that the above participant was able to be a part of subconsciously. Gabriela also alluded to the importance of peer networks for LGBTQ+ students, but also the more universal importance of connecting with others you can relate to, saying *"It's interesting that... my whole friend group is queer, but when we became friends we didn't really realize it... we were all kind of like drawn to each other... we subconsciously found people who are similar to us and that's not entirely related to, like queerness or sexuality… like I feel like that works in all walks of life."*

The importance of informal peer networks in youth sexual wellbeing, and particularly for queer youth is well documented in the literature. For example, informal peer networks were also something cited in the literature as a way young people filled in the gaps in sexual knowledge they had, although it was seen as a fallible method of doing so (Haley et al., 2019). This testimony then provides a nuanced image of friends as a source of sexuality information and support, wherein participants noted that friends were instrumental in creating safe spaces of learning, connecting them with resources, and providing sources of support, but were likely not reliable as participants' primary source of sexual knowledge.

Peer Education Programs

Formal peer networks identified by participants included the Youth Action Board at New Beginnings, Planned Parenthood's Peer Education Program, and other groups which deliberately equip youth with information and skills to be passed on to other young people. Participants also felt strongly about the formal peer education spaces they were a part of as supports for their sexual wellbeing. Sam described how: *"When I tell people that I'm a peer educator, they have questions that I'm like, I can't believe that you've been having this question this whole time and you haven't talked to anyone about it. And these are people who went through health class."* They also emphasized the importance of peer-peer connection: *"I have to shout out the peer education program. I think that's such a great idea to have young people talking to other young people because it's scary and awkward to ask certain questions to*

the adults in your life." She discussed the space of vulnerability and trust that he sees open between young people about topics like sexuality, which are usually uncomfortable to breach, and how they personally create this space by being able to talk about sexuality in an open and casual way: *"Part of it is being vulnerable and being willing to talk about it. Like, here's this exciting thing... and it's not gross, it's not TMI, it's not personal. And there are ways to talk about sexual health that don't get into the heavy details... that's not my business… you can have conversations about sex as a whole that aren't uncomfortable. A lot of times being that first person to share your experiences or your knowledge helps people open up."* Their testimony illustrates the power this vulnerability and openness from a peer has on other young people, who then feel as though they can speak out about things they hadn't felt comfortable bringing up in other spaces. Part of the reason described by participants why peer education was effective in getting information to young people was the absence of an adult in the interactions between them, who youth may see as not safe to divulge personal information to. This fear of asking adults questions about sexuality can be understood in the context of the societal stigmatization of youth sexuality and the way participants felt discouraged from discussing or even thinking about sexuality. Young people may be hesitant to ask adults for advice or guidance surrounding sexuality because they're afraid of getting in trouble for speaking up or doing something they feel they're not supposed to.

Gale described in depth the way in which peer outreach training on the aforementioned McKinney Vento Laws equipped him with information, which, had he had access to earlier on, would have allowed him to stay in school when he became homeless. He described how empowering it was to have this information as well as the skills to now share it with other youth. He described how, *"we did trainings as YAB [Youth Action Board] to... open up... and look for like indicators and just spread resources around. You can't really just be like, "Hey, you homeless?", so instead just having those resources up and having other youth in the community, like other students know about it helps... 'cause if a student goes to another student, it's like, Hey, bestie, I got a solution for you."* This participant was able to identify the ways peer support and outreach are vital to reaching youth who may be experiencing homelessness or unstable access to shelter or housing. He became a peer educator through the youth

specific programming at the community shelter he had been temporarily and sporadically living in, since he was a young teenager.

This particular testimony allows us to closely analyze the ways in which the legal/political system and networks of community care, both those established by New Beginnings and those among homeless youth, interact with one another to allow youth to overcome adverse life events and barriers to their overall wellbeing, including their sexual wellbeing. While formal legal and political protections for homeless youth exist, this young person points out how they're can be inaccessible, because of a lack of knowledge both of those who are in the designated position of implementing these protections, and those who require access to these legal protections. Another factor making the protections inaccessible is a lack of outreach between those who may know of or be able to offer the protections homeless youth are legally entitled to, and those youth who may need these protections and not know of them. In this case, this participants' testimony offers an example of how training youth who have experienced homelessness on peer outreach can bring this knowledge into youth spaces, and offer a more accessible point of contact for young people who may need help but not know how to ask for it or who to go to, and who will likely feel more comfortable speaking to a peer rather than an adult or authority figure. This also goes back to the idea that many young people don't know what they don't know, and the importance of direct individual outreach and making information readily available for those who don't know to seek it out.

Both participants in formal peer education programs identified being drawn to these programs because of their desire to know more about their own sexuality, but also to help others who they saw needing the same information they were finally receiving. One participant described receiving a stipend for their trainings as an important incentive, but also something that drew them into spaces where they could learn. Gale described it as empowering to help other youth, as his knowledge and lived experience as a young person, and in particular, a young person experiencing homelessness was treated as something valuable. The literature also emphasized the merits of peer-to-peer sexuality education in various settings, such as in the U.K. (Strange et al., 2002), in the Netherlands (Cense et al., 2020); and on college

campuses in the U.S. (Bowling et al., 2022), but it is rarely mentioned in the ways in which these participants have brought it to light.

Openness, Care, Acceptance, and Encouragement from Adults

Home Environment as an Open and Safe Space to discuss Sexuality

Sam was the only participant who described having an open family where they could discuss sex and sexuality. She noted the large impact this had on them, saying *"I think that definitely my family has made a really big difference, because it's not as taboo and gross at my house, we're able to joke about it a little bit. Sometimes my dad's jokes are gross. But, I think that that's probably one of the biggest factors that makes me comfortable doing this sort of work."* This openness within their family has also allowed him to provide interpersonal support to their younger sibling as this sibling became a teenager and began to explore his sexuality, also enabling him to access sexual healthcare and resources. Sam recalls, *"I was the first one to buy him condoms and... I think it's been really nice for me to be able to be a big [sibling], and talk to him about consent, condoms... as he's navigating growing up and… learning about his sexuality… he'll... pretend that he hates it, but then he'll still come to me."*

This testimony illustrates the importance of breaking this silence on sex and sexuality at home, even with dad jokes that young people might think are gross. They didn't say that their family talked about sex all the time, but it just wasn't as stigmatized in their household as it can be outside of their house. This participant indicated the way that sexuality is discussed doesn't have to be perfect, but the way their family acknowledged it as a part of the human experience had a large impact on them, even bolstering their confidence in choosing to study and work in the field of sexuality and sexual health. This represents a positive deviation from trends in parental discussions of sexual health with their teenagers as mentioned by Elliot (2010). In the literature, the importance of adult acceptance, affirmation, and respect of young peoples' agency is named by Romeo and Kelley (2009) as associated with lower levels of

depression and increased self-worth. Further, the authors note that adults who are accepting are more likely to be identified by young people as safe adults who they can have personal conversations with and come to with difficult questions or problems in their lives (Romeo and Kelley, 2009).

Encouragement and Openness Towards Discussions on Youth Sexual Health

Participants described how a major support for being able to practice sexual wellbeing were instances where their curiosity and interest in sexual health or desire to ask questions on sexuality was met with encouragement, rather than judgement or fear of risk from the adults around them. Some participants reported that this encouragement allowed them to be connected with the organizations and resources that were able to provide them with vital education and support for their sexual wellbeing. As Sam discussed: *"I was on the Maine Boys to Men Youth council… Because I was on RSVP at my high school... And then I went to the youth council... [the person], who runs it put out a thing saying apply to be a peer sex educator…and that's before I was really that interested or passionate about sexual health, but I just wanted to keep doing the type of work that I was doing with RSVP and Maine Boys to Men… because that was mind blowing conversation for me at that point… And I was really excited to be part of it."* Opportunities such as this, to join spaces and connect with peers on sexual health can play a huge supporting role in both that individuals' sexual wellbeing, and that of those around them, as they build and expand upon existing peer networks of sexual health knowledge transfer and support.

Encouragement and acceptance were particularly impactful for queer participants who did not receive these supports at home. Receiving information on LGBTQ+ identities or being encouraged to join youth groups, LGBTQ+ and sexual health organizations, or different programs where youth can connect with others on sexuality opened doors to these opportunities for participants. Sam described how a favorite librarian of theirs was a champion of LGBTQ+ acceptance and asked them to give a presentation on supporting queer youth at the library which was geared towards community members. Gale recalled one teacher who *"was the only person in the whole school you could go to about being LGBTQ."* Sam

who had an overall positive impression of sex education, even if it was lacking in relevant content, talked about how they felt comfortable enough to go back to his instructor and ask her to include something they found was missing from the curriculum. Sam told this story: *"I also remember going to the health teacher… as a senior and talked to her about the curriculum and she was willing to make some changes based off of my knowledge and what I said that I wanted to see… I asked her like, would you be willing to like change the language a little bit? So it's like, is this male anatomy, female anatomy, or intersex slash everyone? And to explain a little about what being intersex was… And it was so cool that she was not only receptive to that, but that when my brother went through it, He said that she actually made those changes. That was amazing."*

For both participants who experienced instability and violence in their homes, having adults outside of their homes who demonstrated that they cared, and were able to provide interpersonal support, had a significant positive impact on their wellbeing. Helena, who also has a disability and described experiences of medical ableism and discrimination, recalled how having her family friend accompany her to a clinic allowed her to access the sexual and reproductive healthcare she needed: *"I went to Planned Parenthood and she came with me 'cause I did not wanna go by myself… I'm not going if I have to do it myself. So she was able to come."* Gale who was unsafe in his home particularly because of his trans identity, remembered the important roles that accepting teachers or counsellors had in his life: *"We ended up having a lunch meeting with our counselor or social worker in school… we sat down, me, my friend... we just all talked about it and… I got special exemptions from class to go talk to her. It was so nice to be able to talk about it. 'Cause then like maybe a year and a half later, I found myself as trans and everyone back then... was like, oh, it's just a trend. It's a phase. And then here I am five years later, still trans, like, wasn't a phase. My mom's just now calling me by my chosen name. It's still hard for her."* Being able to identify which teachers could be safe to talk to as an LGBTQ+ young person also played a role in the participant being able to access this support. Gale recounted, *"I found out what the rainbow was in the corner of her door... Safe space. I didn't get it right away, it was like, okay, safe space in general. Cool. I'll go there."* In this case, the counsellor had a safe space sticker on their door, leading the participant to

their room and a vital support. Even being able to identify one safe adult he could talk to, who allowed him to miss class, and bring his friends, demonstrating care for him as a person, beyond his role in the school as a student, made a huge difference for this participant. Thus, the participants demonstrate how adults who are encouraging and accepting of youth sexual wellbeing, and especially that of LGBTQ+ youth have the power to provide interpersonal support, and even create safe and welcoming spaces within larger communities who may be unaccepting, providing a large support for many young people.

Chapter 5: Conclusion and Recommendations

This paper has offered an in-depth look at the ways in which four contemporary youth in rural U.S. understand, define, and practice sexual wellbeing. The participants of this study shared with me so much lived knowledge and expertise on the subjects we discussed, and their contributions of critical self-analysis, and deeply personal and emotional testimonies cannot be overstated. This type of research represents a valuable addition to existing studies on North American sexual health and wellbeing. It centers youth knowledge as the primary data and shines a light on the participants' own definitions of sexual wellbeing as the premise for understanding barriers and supports to their sexual wellbeing. Adopting the definition of sexual wellbeing as self-exploration, self-determination, and self-care, requiring interpersonal support, access to resources, education, and safe spaces shaped the direction of this research. The study offers important insights into barriers to sex education in Maine, such as experiences of violence, denial of education, and access to resources, as well as a lack of interpersonal and community support. These barriers are independently significant but overlapping challenges must also be addressed through an intersectional lens. The research for this study was also vital in identifying the ways in which community organizations, safe and open spaces of learning, peer networks, and encouragement from adults could be valuable supports for Maine young people as they navigated processes, struggles, and opportunities for sexual wellbeing. While this project contributes significant insights into the experiences of gender-diverse and queer youth and their access to sex education in

Maine, additional research is needed to better understand how sexual wellbeing shapes the lives of young people, and particularly, how it is conceptualized and experienced by young people from diverse backgrounds, identities, and experiences across the world. The findings from this study can inform future research building on the insights from queer youth as well as the need for an intersectional lens for studying sex education. Based on the findings of this study, recommendations for future research include:

1. An increased use of qualitative, participatory, and holistic methods in exploring sexual health, sexuality education, and sexual wellbeing.
2. Further inquiries into the sexual wellbeing of adults, and how sexual wellbeing is shaped intergenerationally.
3. Specific research on experiences of sexual wellbeing for people of color, people with disabilities, and queer and trans people of all ages, as well as experiences of sexual wellbeing in the intersections of these identities.
4. A more widespread adoption of sexual wellbeing as a concept through which to explore experiences of sexuality, sex education and sexual health in multiple settings, particularly within the public-school systems across the U.S. and the American physical and mental healthcare systems.
5. Replications of this study with different populations and possibly larger sample sizes in local settings. This study included four different young people in Maine and the findings would likely offer very different life experiences if the research was carried out with four different participants.

Several non-research recommendations also emerge from this study. These recommendations include:

1. Specific and trauma-informed domestic and sexual violence supports for Maine youth: Participants described how isolating and inhibiting experiences of domestic and sexual violence were to their overall health, and to their sexual wellbeing. They discussed how violence impacted the way they were able to navigate everyday experiences, making things such as accessing healthcare, making friends, and going to school much more difficult than for those who do not

experience this type of violence. It's clear that young people who experience violence need specific supports, and it's also evident that any supports offered must consider the intersectional experiences and needs of those who experience violence, including gaps in typical services including public education, health care, and reproductive and sexual healthcare which may render them inaccessible to youth impacted by violence.

2. Centering community organizations as hubs of sexual wellbeing: The role of community organizations in providing safe spaces, resources, education, and support for participants was a centerpiece in participants' testimonies. As was previously discussed, this project sought to deliberately explore what contributes to sexual wellbeing outside state-led, formal, or political solutions because of their demonstrated nonviability in driving positive change and their entrenchment in sexual and reproductive oppression. Also previously acknowledged, is the implicit bias within the recruitment strategy as the research was done in partnership with Maine Family Planning, a community-based nonprofit. The recruitment took place within its networks of youth serving organizations, leading to participants who were likely to discuss the role of community organizations in promoting sexual wellbeing in a positive manner. While this is a bias of the results, the goal and nature of the research was not to make sweeping or definitive claims about youth sexual wellbeing in Maine but rather to further explore and analyze young peoples' lived experiences of it. Offering the participants' definitions of sexual wellbeing and their descriptions of barriers and supports in accessing sexual wellbeing provided real life examples of how young people in Maine understand and engage with the concept. These definitions, therefore, add nuance to our understanding of how human sexuality is experienced in the particular contexts of this project. These participants described the community organizations they accessed positively because that was their experience. Their experiences showed that within these organizations, the oppressive societal norms which served as significant, omnipresent, compounding, and long-lasting barriers to study participants' sexual wellbeing, can be subverted in favor of norms of non-judgement, inclusivity, respect, and acceptance for young people and their sexual experiences.

These experiences were not found as easily in their households, schools, or other spaces in their community. This analysis on participants' testimony also illustrates that this project's positive bias towards community-based organizations may be reinforcing, because, as previously mentioned, community organizations, rather than other institutions, may be the main or only channels through which participants had the opportunity to engage with sexual wellbeing, and participants might have not been equipped to participate in the study in the same way without this key support. Further, community organizations which subvert or work to disrupt norms of reproductive and sexual oppression may be more likely to support research on sexual wellbeing or engage with gender diverse youth and/or researchers. Accessing these spaces of positive norm creation was often described as a "mind blowing" experience for participants different than anything they had previously experienced, and often marking the first time they felt comfortable, safe, and had their needs met in a way that enabled them to begin to practice sexual wellbeing and learn about their own sexuality. Support for community-based organizations as leaders in promoting youth sexual wellbeing should be a focus for future youth sexual health interventions.

3. Multi-contextual, continuous, sex-normalizing sexuality education which includes the diversity of lived experience: A key aspect of participants' experiences of impactful and effective sexual health learning was their continuity. Learning about human sexuality should be treated as a vital, healthy, and normal piece of young people's lives. It should not be relegated to specific spaces, times, or circumstances. Participants demonstrated how the continued trainings, courses, and discussions, offered by community organizations and advocacy groups they joined met this need of sexuality education beyond ideas of preparedness and prevention, towards continuous and holistic learning which can be applied throughout their lives in multiple contexts. These learning opportunities were also not only offered to adolescents. By placing learning and conversations on sexuality into the spaces where sexuality is experienced – everyday life – participants observed that spaces are opened where adults are able to talk to other adults about sexual wellbeing, and cross-generational conversations and learning can occur. This normalization of sexuality and

conversations surrounding sexuality serve to disrupt societal norms ingrained by settler-colonialism and reproductive and sexual oppression, through acceptance, support, sharing information, valuing young people as knowledge holders, and normalizing those human experiences, feelings, and identities for which stigmatization and marginalization has been naturalized. In this way, sexuality education that centers normalization, openness, and acceptance disrupt the naturalization of oppressive conceptualizations of sexuality which have long suppressed knowledges related to human sexuality, allowing for young people and all people to begin to reclaim these learning experiences on their bodies, identities, and sexualities without shame.

4. One-on-one or small group education and specific accommodations for youth with disabilities: The two participants with disabilities emphasized factors certain factors which were vital to their ability to gain knowledge on sexuality, such as having the interpersonal support of an instructor who could sit down with them individually and answer their specific questions, being in a space where they were respected and listened to, and receiving accommodations that enabled them to learn. Accessibility considerations and accommodations such as having instructors speak slower or having a quiet learning space made a difference for them in gaining vital information they had been missing as they went about practicing sexual wellbeing.
5. Establishing peer-peer education and outreach networks and building peer networks from one safe space to another: As described by participants, formal spaces created for or by youth to get together can deliberately or even inadvertently create networks of learning and support between young people on sexuality, and can have large impacts beyond the group, given how participants observed peer-to-peer knowledge transfer happening anywhere youth are interacting with one another. Building upon and between existing formal and informal peer networks has the potential to be a successful strategy of leveraging their benefits, as participants described how they were often connected with safe spaces through friends or peers, or through other safe spaces they were already a part of. Even participants facing intersectional barriers who recounted the difficulty they

had in finding spaces they feel like they belong, felt emboldened to seek out additional safe spaces if they learned of them in a space where they already felt comfortable. It's also important to note that both the formal and informal peer networks of knowledge transfer described by the participants inherently created spaces of learning between youth that had the characteristics of an effective setting for learning, such as emphasizing safety and comfortability as a prerequisite, accommodating different learning styles, interpersonal support, and continuity in learning, because the education happens through casual conversation, sharing experiences, and building relationships with others, in one-on-one and group settings. Peer networks of learning also inherently recognize the agency and value of young people and their expertise, as well as the knowledge they hold within their lived experiences. School-based sex education tends to undermine the agency of young people by assuming they are too driven by their sexual desires to be trusted with knowledge on sexuality. This harmful assumption is disrupted by peer education, which empowers young people to build networks among themselves and gives them tools to act on and enhance their agency as leaders in their communities.

6. Explicitly advertised groups and spaces, resources, information, and groups specifically for LGBTQ+ youth, youth with disabilities, and other marginalized youth: Explicitly designating spaces for those of identities which have been marginalized by settler-colonial norms of sexual and reproductive oppression is particularly important because of their historical denial of safety, and access to spaces of belonging. Allocated spaces for queer individuals, or individuals with disabilities, or queer individuals with disabilities, has the potential to expand outreach to these young people and allow them to access other aspects of sexual wellbeing they have been historically denied, such as relevant sexuality information, interpersonal support, and community acceptance.
7. Training individual adults as beacons of support within unequal systems and unsafe spaces: The study participants spoke of the value they placed on individuals who stepped in when mainstream care structures, such as schools, the healthcare system, or even families, failed to provide paths to

wellbeing for young people. Individuals within these institutions, i.e. educators, counselors, therapists, family members, healthcare and service providers, a favorite teacher or librarian, among others, can still be beacons of support for struggling young people. The participants appreciated the role that these supporters provided by listening to them and guiding them to where they could find systems of support and care or being the one to suggest implementing LGBTQ+ inclusivity, anti-racism, accessibility, or other norms of acceptance, respect, and safety in their classrooms or programming. Supportive adults can provide particularly crucial supports for young people who encounter many barriers to practice sexual wellbeing, such as violence or discrimination against their identity, as they may be the only welcoming or supportive adult in those young persons' lives, and the only one they feel they can go to ask questions or access resources. In this way, individual adults can drive norm creation, sex normalcy, and create safe spaces or hubs of sexual wellbeing where they are, by being open, accepting, respectful of youth agency and identities, and listening to young people as valued knowledge-holders and important members of their communities. By offering training on how to be a beacon of support and accept and encourage youth, educators, healthcare providers, parents, community members, and any adults can be champions of youth sexual wellbeing in their communities.

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