

School-based sexuality education experiences across three generations of sexual minority people

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Abstract

Sexual minority people face greater risk for compromised sexual health than their heterosexual peers, yet school-based sexuality education often excludes them. Little is known about whether or how sexual minority people's sexuality education experiences have varied across sociohistorical contexts of rapid social change in both sexuality education and sexual minority visibility. Semi-structured qualitative interviews were conducted among 191 sexual minority people from three distinct sociohistorical generations (ages 18-25, 34-41, and 52-59, respectively) and four geographic regions of the United States. Data were analyzed using thematic content analysis following a consensual qualitative protocol. Fifty-one participants (i.e., 27%) discussed school-based sexuality education experiences despite the lack of an explicit question in the interview protocol prompting them to do so. Four distinct yet overlapping themes emerged in participants' experiences of sexuality education: 1) Silence; 2) The profound influence of HIV/AIDS; 3) Stigma manifest through fear, shame, and prejudice; and, 4) Comparing school-based experiences to sexuality education outside of school. The presence of themes varied across groups defined by sociohistorical generation. Implications of sexuality education experiences on the wellbeing of sexual minority people are discussed.

Keywords: Sexuality education; sexual minority; qualitative research

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School-based sexuality education programs can promote healthy decisions about sex, sexuality, and romantic relationships across the lifespan (Ansuini, Fiddler-Woite, & Woite, 1996; Blake et al., 2001; Kirby, Laris, & Rolleri, 2007). For sexual minority (e.g., lesbian, gay, bisexual, queer) people in particular, inclusive and accurate school-based sexuality education can provide access to critical sexuality information that may otherwise be inaccessible from common sources of sexual socialization such as family or peers (Elia & Tokunaga, 2015). Despite a growing literature and clear recommendations from leading sexuality education organizations in the U.S. underscoring the need for inclusive sexuality education (Future of Sex Education Initiative, 2020), school-based sexuality education programs often exclude sexual minority youth (i.e., SMY) by omitting information about sexual minority attraction, identity, healthy sexual behavior, and romantic relationships (Elia & Tokunaga, 2015; Kubicek, Beyer, Weiss, Iverson, & Kipke, 2010; McNeill, 2013). This exclusion likely contributes to the persistence of sexual health inequalities among sexual minority people relative to their heterosexual peers, including higher rates of HIV/AIDS (Mustanski, Newcomb, Bois, Garcia, & Grov, 2011) and unintended pregnancy (Charlton et al., 2013) in specific subpopulations of sexual minority people.

By documenting sexual minority peoples' first-hand experiences in school-based sexuality education, researchers can elucidate the role of sexuality education in sexual minority-specific inequalities. A small literature has emerged describing the experiences of SMY in school-based sexuality education. SMY educated in the United States commonly report erasure resulting from curricula that excludes information about sexual and gender minority attraction, behavior, and identity (Kubicek et al., 2010; Pingel, Thomas, Harmell, & Bauermeister, 2013; Steinke, Root-Bowman, Estabrook, Levine, & Kantor, 2017); experiences of marginalization

(Elia & Eliason, 2010; Gowen & Wings-Yanez, 2014); fear stemming from master narratives of risk and illness (Estes, 2017; Fisher, 2009; Hammack & Cohler, 2011); content focused on abstinence, sexually transmitted infections, and pregnancy (Fisher, 2009; Kubicek et al., 2010); and a lack of adequate and accurate knowledge for engaging in sex safely regardless of sexual orientation (Rose & Friedman, 2017). Although these studies have shed important insight on SMY's experiences in sexuality education, they have only recently emerged and therefore represent contemporary experiences. As such, little is known about whether and how SMY's experiences of sexuality education have changed over time across distinct sociohistorical contexts.

Access to sexual health education is crucial for healthy sexual behavior. Such education has been ignored or limited for many groups including sexual minority people (Schalet et al., 2014), and the absence of that access is implicated in decades of sexual orientation-related sexual health inequalities (Coker, Austin, & Schuster, 2010; Saewyc, Poon, Homma, & Skay, 2008). We argue that an important component of understanding sexual minority peoples' current sexual health may involve looking back at school-based experiences to understand access to sexuality education. Both sexuality education and understandings of sexual minority lives and health have changed rapidly over the past 40 years. Thus, voices from across distinct sociohistorical generations could elucidate how sexuality education is embedded in sociohistorical contexts, which components of sexuality education have changed and remained over time, and ultimately, how to improve school-based sexuality education programs for SMY.

Sociohistorical Changes in Sexual Minority Visibility and Education

In the past several decades, there has been significant social change with respect to sexual minority visibility. Simultaneously, there have been important changes in the focus and emphasis

of sexuality education in the United States. In the 1960s and 1970s, sexuality education programs emphasized “hygiene” in response to the “pregnancy panic” linked to rising teen pregnancy rates (Huber & Firmin, 2014). Founded in 1964, the Sexuality Information and Education Council of the United States (SEICUS) led early efforts to train sexuality educators to deliver scientifically informed curricula to adolescents. These curricula were focused on reducing teen pregnancy and therefore largely excluded the unique needs of SMY (Huber & Firmin, 2014; Irvine, 2004). The American Psychiatric Association’s decision to add homosexuality to the Diagnostic and Statistical Manual of Mental Disorders (DSM-II, 1968) reflected a continued societal stigmatization of non-heterosexuality despite improvements in sexual minority visibility. In 1969, one year after the inclusion of homosexuality in the DSM, the Stonewall Riots occurred in response to a police raid of a gay bar in New York. This response to what had become frequent harassment of patrons of gay bars in New York City is considered to be a founding moment of the gay rights movement (McGarry, 1998). Sexual minority people coming of age during this period were living in a society increasingly tolerant of homosexuality; however, because sexuality education remained heteronormative, sexual minority people did not have access to inclusive school-based sexuality education.

The HIV/AIDS epidemic of the 1980s and 1990s fundamentally altered both sexual minority visibility and sexuality education. The government’s response to HIV/AIDS in the early 1980s reflected silence and ambivalence (Dowsett, 2009). The Reagan administration systematically withheld federal funds for research and education amid concern that funding such programs would be viewed as promoting homosexuality (McGarry, 1998). In 1982 and 1983, despite rising incidence rates of HIV/AIDS across diverse populations, no funds were allocated by the federal government for HIV/AIDS research. By 1984, Margaret Heckler, the Secretary of

Health and Human Services, publicly announced the discovery of the HIV virus and promised that HIV/AIDS would be stopped before it reached the “general population” (i.e., heterosexual people; McGarry, 1998). In response, AIDS activist organizations such as the Gay Men’s Health Crisis and the AIDS Coalition to Unleash Power (i.e., ACT UP) organized major protests to call out government and media silence around this public health crisis and promote awareness about the growing epidemic.

As it became increasingly evident that HIV/AIDS could be transmitted through both same- and other-sex sexual activity, the government could no longer ignore the need to educate adolescents about sexual behavior. By 1986, a Surgeon General’s report on AIDS called for a nationwide education campaign, including the need for school-based sexuality education coverage of HIV/AIDS (HIV.gov, n.d.). Between the 1980s and 1990s, HIV/AIDS was increasingly included in sexuality education curricula (Lindberg, Ku, & Sonenstein, 2000). One nationally representative study of adolescent and young adult men found that between 1988 and 1995, the percentage of young men reporting coverage of AIDS in their sexuality education courses jumped from 72.8% to 96.5% (Lindberg, Ku, & Sonenstein, 2000). Fear-based messages were at the foundation of emerging HIV/AIDS sexuality education curricula, which sometimes explicitly linked HIV/AIDS to same-sex sexual behavior (Fairchild et al., 2018). Thus, youth experienced sexuality education that was increasingly informed by the HIV/AIDS epidemic as public perceptions of the connection between gay identity and risk for HIV/AIDS solidified.

Fear-based messages linking sexual behavior with disease and immorality prevailed as the dominant narratives in politics and sexuality education in the late 1980s. At the same time, abstinence began to be promoted as a tool for reducing risk and disease associated with HIV/AIDS (Irvine, 2004). In 1987, the U.S. Senate adopted the Helms Amendment, which

required federally funded educational materials about HIV/AIDS to stress abstinence and forbid any materials that “promoted” homosexuality or drug use (HIV.gov, n.d.).

During the late 1990s and early 2000s, abstinence only education (AOE) was advanced through a series of funding programs exclusively reserved for AOE sexuality education. In 1996, as part of the Personal Responsibility and Work Opportunity Reconciliation Act (PWORA), federal support for AOE was significantly expanded through the Title V AOE program, which funded programs that promoted only abstinence and restricted access to other information (Santelli, 2017). Sexuality education programs that were funded by Title V programs were required to have as their exclusive purpose the promotion of abstinence until (heterosexual) marriage (Santelli, 2017). Despite a government report released in 2004 describing that the majority of AOE programs contained misinformation about reproductive health, sexually transmitted infections, and pregnancy, as well as moral judgements about sexual and gender minority people, funding for AOE programs grew through 2017 (Santelli, 2017). The enduring focus on AOE for the following three decades was a barrier to all youth learning information to make informed decisions about their sexual health, and further stigmatized SMY.

The dominance of AOE served to sustain the marginalization of sexual minority people through the early 2000s, until social changes such as legal recognition of same-sex marriage in states like Massachusetts in 2004 and California in 2008 helped to shift public opinions. A combination of growing access to comprehensive sexuality education paired with educators’ and researchers’ recognition of the unique health needs of sexual minority people has helped to foster movement towards more inclusive sexuality education. However, this movement has stalled partly because educators and researchers have little understanding of how to make sexuality education fully inclusive of sexual minority people.

Despite shifts in the historical context of sexuality education and progress towards more inclusive sexuality education, contemporary sexuality education is still largely exclusive of the experiences of SMY (Elia & Eliason, 2010; Fields, 2008; Schalet et al., 2014). As educators and researchers seek to develop inclusive sexuality education, examining the first-hand educational experiences of sexual minority people across distinct generations can provide insight into the lasting meanings and implications of sexuality education during discrete sociohistorical periods, and over the life course.

The Current Study

Given significant changes in both sexual minority visibility and sexuality education curricula and policies, the current study draws from a diverse sample of sexual minority participants across three distinct generations and four geographic regions to examine first-hand experiences of school-based sexuality education. Guided by a life course approach (D'Augelli, 1994; Elder, Johnson, & Crosnoe, 2003), which contends that lived experiences are embedded in specific sociohistorical and developmental contexts that fundamentally shape them, we investigate the following research questions: How do sexual minority people across three generations experience sexuality education in school? How do sociohistorical contexts shape these experiences? In doing so, we further elucidate the association between SMY's sexuality education experiences and the cultural, historical, and political contexts in which they unfold.

Materials and Methods

Data

Data for this study came from the qualitative portion of a multi-institutional, multi-method study designed to measure identity, stress, and health among three generations of sexual minority people in the United States (Frost, Hammack, Wilson, Russell, & Lightfoot, 2019). Each generation reflects a distinct sociohistorical context in the United States. Individuals aged

52-59 years represent the oldest (i.e., “Pride”) generation, who were in secondary school (i.e., ages 10-18) between 1966-1981. They were the first generation of sexual minority people to come of age following the Stonewall Inn riots. Participants aged 34-41 represent the middle (i.e., “Visibility”) generation and attended secondary school between 1984-1999. They entered adulthood at the height of the HIV/AIDS epidemic. Last, those aged 18-25 represent the youngest (i.e., “Equality”) generation and attended secondary school between 2000-2015. They were adolescents amid discourses focused on equality and increasing cultural and legal inclusion. A full description of the methodological approach for the qualitative study is available in prior work (Frost et al., 2019).

Participants and Recruitment

One hundred and ninety-one participants were recruited into the qualitative component of the Generations study. Participants lived within 80 miles of four urban regions in the United States: San Francisco, CA, New York City, Tucson, AZ, and Austin, TX. The study team used a targeted nonprobability sampling strategy, identifying key physical venues such as cafes, parks, bars and clubs, and restaurants patronized by sexual minority people in each of the four sites (Meyer, Schwartz, & Frost, 2008). The study team avoided recruiting from venues that overrepresent people with mental health issues and/or stressful life events (e.g., substance abuse programs, HIV/AIDS service providers) in order to reduce bias inherent to community samples. Study advertisements were also posted in local social media outlets. Trained research workers recruited individuals by providing information about a study website and toll-free number where screening for eligibility was conducted.

Eligibility criteria included: 1) self-identification as lesbian, gay, bisexual, or another non-heterosexual orientation; 2) self-identification as a cisgender man, cisgender woman, or as

genderqueer; 3) aged 18-25, 34-41, or 52-59 at the time of recruitment; 4) held residency in the United States between ages 6-13; 5) completed at least sixth grade of school and 6) A spouse or partner was not already enrolled in the study. Selection for interviews was designed to include at least two persons for each category defined by study site, generation, gender, and five racial/ethnic identity groups: self-identification as White or Caucasian, Asian/Pacific Islander (API), African American or Black, Hispanic/Latino, American Indian/Alaska Native (AI/AN), or Bi-/Multi-racial. Data were collected between April 2015 and April 2016.

This study was designed to include LGB individuals; during the course of the study participants were free to self-identify using their preferred labels, some of which extend beyond “lesbian,” “gay,” or “bisexual”, and male or female. For the purposes of this study, we use participants’ preferred identity labels when quoting the participants, and “LGB” to describe the sample as a whole.

Interview Protocol

Following an initial screening, enrolled participants met with trained interviewers who used a semi-structured qualitative interview protocol. Participants were asked to construct a life-story narrative, and then were asked questions about social identities and communities, sex and sexual cultures, challenges and coping, social and historical movements, and healthcare utilization. There was no explicit question in the interview protocol about sexuality education experiences. Interviews were recorded by the study team, transcribed by a professional transcription service, and uploaded to the qualitative software Dedoose (SocioCultural Research Consultants, 2018).

Data Analysis

This study examines the extent to which first-hand accounts of school-based sexuality education emerged organically in narratives of identity and health among a diverse group of sexual minority people. In order to examine our research questions, we engaged in three stages of analysis. First, the study team developed a set of keywords related to sexuality education in school to identify segments of analysis. Keywords included: sex; health class; abstinence; HIV(education); AIDS(education); IUD; birth control; protect(-ion); condom; myth(about sex); message(about sex); birds and the bees; learn (about sex); STI, STD; safe sex; prevention; dental dam; consent; pregnan(-t/-cy); and PrEP. The keyword “sex” was used as a root such that any word or phrase that contained “sex” (e.g., “sexual”, “sexuality”, “sex education”) was examined. Coders screened all qualitative interviews for instances when the keywords were used in relation to sexuality education.

Next, the study team established a set of inclusion and exclusion criteria for segmenting data relevant to our research question. Excerpts were included in the analytic sample if they: 1) Described a first-hand school-based sexuality education experience; 2) Described an experience occurring in secondary school or earlier (prior to college); and, 3) Described an experience that was part of formal instruction.

Finally, guided by a consensual qualitative protocol (Hill et al., 2005), a team of four coders representing diverse genders, sexualities, race/ethnicities, generations, and levels of experience conducted thematic content analysis (Braun & Clarke, 2006) to elicit key themes. A sub-set of excerpts were open-coded by each coder. The coding team then met to conceptually map similarities and discrepancies across codes to develop initial themes. Two members of the coding team applied codes to the remaining excerpts, and final themes were developed through an iterative process of application and adjustment to the remaining set of excerpts. Consistency

between coders was enhanced through a method of bi-weekly team meetings involving extensive discussion of coding application, consensus-building, discrepancy resolution, and reflection (Levitt et al., 2018).

Results

Despite the absence of a specific question about sexuality education in our interview protocol, 61 excerpts from 51 participants (i.e., 27% of the full study sample) described school-based sexuality education experiences. Twenty-eight participants were from the youngest generation, eighteen were from the middle generation, and five were from the oldest generation. Those who comprised our analytic sample were diverse with respect to sexual identity, gender identity, race/ethnicity, and education level (see Table 1). Discussions of sexuality education most commonly occurred when participants were asked: 1) *Can you tell me about how you thought about sex and relationships during puberty and adolescence?*; 2) *What do you remember about how LGBT issues were talked about in the wider society and during your childhood and adolescence?*; and 3) *Were there any things that scared you about sex when you were younger?* In three interviews, the interviewer raised the topic of sexuality education prior to the interviewee.

Coders identified four distinct yet overlapping themes characterizing participants' experiences of sexuality education: 1) Silence; 2) The profound influence of HIV/AIDS; 3) Stigma manifest through fear, shame, and prejudice; and, 4) Comparing school-based experiences to sexuality education outside of school. We argue that these themes are meaningfully distinct, yet capture dimensions of experience that are often intersecting. For example, the influence of the HIV/AIDS pandemic often acted as a shadow in the foreground of the themes of silence and stigma. We focus our analysis on generational comparisons of themes

to reveal the ways in which sociocultural and historical contexts shape SMY's experiences of sexuality education. We present key themes derived from our analysis, beginning with themes present across all generations and working forwards in historical time. When presenting data from specific participants, we assign pseudonyms to participants in order to preserve their anonymity while also specifying the source of an excerpt.

Silence in Sexuality Education

A common and pervasive theme across all three generations was silence, described as an absence of sexuality education, critical omissions in sexuality education, and heteronormativity. While the theme of silence occurred in the narratives of participants across each of the three generations, descriptions and meanings of silence differed by generation.

Absence. Participants predominantly from the youngest and oldest generations discussed the explicit absence of sexuality education in school and described a dearth of information regarding sex and sexuality. Anna, a White lesbian female from the oldest generation, described feeling "highly confused" about sex and sexuality, and Shane, an Asian gay male from the youngest generation, discussed receiving sexuality information from "the slurs that the young kids would yell at each other." Josh, a Multiracial gay male from the youngest generation, described how the absence of sexuality education in school impacted his access to knowledge about sexual health and HIV/AIDS:

I would talk to my guidance counselor about HIV, just before I even had it. I didn't want her to tell everybody what we was talkin' about, and she told a lotta people what we was talkin' about...I was like, "You're having people think I have somethin' that I don't even have, and I just wanted to get some knowledge on it. Y'all don't teach sex ed in class, so lemme ax questions.

Absence was not specifically discussed in narratives about sexuality education in the middle generation, except from one participant who attended a private Catholic school. This finding is consistent with historical trends in the rise of HIV/AIDS during the late 1980s and 1990s, when the middle generation was receiving sexuality education. During this time, many states had laws mandating school-based HIV education, which often explicitly connected sexuality (and more specifically, homosexuality) with disease and risk (Lindberg, Ku, & Sonenstein, 2000).

Critical omissions. Participants from each generation described critical omissions of information about identity, sexuality, and experience in the school-based sexuality education that they received, and the misunderstanding that resulted. Respondents from the oldest and youngest generations described their sexuality education experiences as abstract with a focus on anatomical terms rather than concrete and person-based information. Sasha, a White lesbian female from the oldest generation, recounted: “I’d had sex ed and there’s a penis and vagina but what that meant in terms of what actually was gonna happen between two bodies, I think until I had sex, I didn’t have a clue, really.” Sasha conveys that abstract and mechanical notions of sex were misaligned with what young people wanted and needed to know about the reality of sexual experience. A quote from Jessica, a Black bisexual female from the youngest generation, demonstrates that contemporary young people continue to learn about sex in ways that omit necessary sexual information:

I had sex ed in eighth grade...it was a six-month course. They opened the health book, and they teach you all of the parts. As far as talkin’ about sex, no. They talk about anatomy. They don’t really talk about emotional or physical—you know?

The examples from Sasha and Jessica describe a focus on anatomical understandings of sex that omitted information that would have been relevant to them regarding the physical and emotional components of sex and sexuality.

Participants from the middle generation reported that sexuality education often omitted information about “actual sex,” and centered messages around the prevention of disease, implying that all sex was dangerous and unhealthy. Rob, an Asian queer male from the middle generation, explained:

[B]asically, sexual education then was ‘You’re gonna get AIDS or a disease.’ The first concepts of sex was safe sex. It wasn’t even like, ‘What is sex?’ It was...just, like, ‘Let’s talk about safe sex,’ and you’re, like, ‘What?’...there was barely any talk about actual sex. It was just all about preventing things from happening to you.

Rather than learning about sex, Rob learned to equate sex with AIDS and risk. Rob’s experience reflects prominent sexuality education trends during the HIV/AIDS panic, when many states mandated HIV education (Lindberg, Ku, & Sonenstein, 2000) that was largely fear-based (Hall, McDermott Sales, Komro, & Santelli, 2016).

Heteronormativity. Among participants in the youngest and middle generations, silence in sexuality education manifested in the form of socialization and privileging of heterosexuality as normative and desirable. Participants like Mai, a Black lesbian female from the youngest generation, described the content of sexuality education as “all female-male sex” and noted that explanations of safe sex were only applicable to heterosexual sex. As such, conversations about safety were centered around “condoms and birth control, and that’s about it.” Brette, an Asian queer female from the middle generation, notes that heteronormative sexuality education contributed to her lack of sexual minority-specific information, saying:

I had sex ed in elementary school but it wasn't something—I don't even really think I thought about gay people or queer people until I was in—late into high school. It just was not present. It was such a heteronormative space.

Additionally, Joey, a White gay male from the youngest generation, describes a general silence around sexual minority status in sexuality education: “I don't remember any LGBT issues ever brought up...They'd always leave out anything about gay or what have you. It was purely straight education.”

People from the oldest generation in our sample did not describe heteronormativity in their narratives about sexuality education. At the same time, fewer participants in the oldest generation mentioned sexuality education in their interviews: they may have been unlikely to have a sexuality education course in school in the first place.

HIV/AIDS in Sexuality Education.

HIV/AIDS was a central and focal theme in the youngest and middle generation participants' discussions of school-based sexuality education; it also permeated other central themes such as silence and stigma. When discussing HIV/AIDS in the context of school-based sexuality education, participants described the relative centrality or exclusion of HIV/AIDS information, and the perpetuation of misinformation relative to HIV/AIDS. Generational differences emerged with regard to centrality and exclusion of HIV/AIDS in sexuality education.

Centrality. Respondents discussed HIV/AIDS as central to their sexuality education and their understandings of sex and sexuality as a young person. All but one of the participants describing this theme were from the middle generation. Rebecca, a Latina lesbian female from the middle generation, recalled:

I remember being taught emphatically about AIDS and HIV in schools in the 80's...I remember being like you can get AIDS from this. You can't get AIDS from this....I remember thinking...you don't hear AIDS without gay guys attached to it or HIV without—even if it's to say that you don't have to be.

For Rebecca and other SMY, HIV/AIDS was both an integral focus of sexuality education, and was often the only conceptualization of sexual minority identity in school.

Misinformation. Respondents also described receiving misinformation about HIV/AIDS in sexuality education. Specifically, participants predominantly from the middle generation learned that sex inevitably results in HIV/AIDS and disease, or that only certain people—sexual minority people and African Americans—get HIV/AIDS. Angela, an American Indian bisexual female from the middle generation, recalled how HIV/AIDS was discussed as evidence that sex is dangerous, unhealthy, and an unavoidable repercussion of sexual behavior: “everywhere on TV and school, they were like, ‘If you have sex, you’re gonna get AIDS.’” Other participants such as Tom, a White gay male from the middle generation, described that sexual minority identity was linked with HIV/AIDS in his school-based sexuality education:

In school, gay things [were] either just totally not mentioned, which was the most common possibility, or like when HIV came up it came up predominantly in reference to gay people and there was a subtext to the health lectures of ‘This is not on you guys’ because it was assumed that everyone in the room was straight.

When HIV/AIDS was included in sexuality education, it was explicitly discussed in connection with sexual minority identity. Tom’s description that all students were assumed to be heterosexual describes how heteronormativity framed his experience of learning that sexual minority identity and HIV/AIDS were fundamentally related.

Notably, learning about sexual minority identity in the context of HIV/AIDS education in school appeared solely in discussions by participants in the middle generation. In the youngest generation, additional misinformation about who gets HIV/AIDS appeared. Brandon, a Black bisexual male from the youngest generation, mentioned the conflation of HIV/AIDS and African-American identity: “I was just like teachers like they’d beat in our head, started in Africa, started in Africa, AIDS started in Africa.” While the content shifted between the middle and youngest generations, misinformation about HIV/AIDS persisted in both generations.

Exclusion. In the youngest generation, some participants noted an exclusion of HIV/AIDS in their sexuality education. Jay, a Latino gay male from the youngest generation explained learning about “traditional sex education things like STDs, getting somebody pregnant, premarital sex, stuff like that. The HIV and AIDS discussion wasn’t really there until I was older.” Additionally, Alex, a Latina lesbian genderqueer participant from the youngest generation, reported minimal exposure to information about HIV/AIDS, saying that they learned about AIDS from “one talk in middle school.” These examples at the cross-section of silence and HIV/AIDS suggest that participants from the youngest generation presumed that sexuality education should include attention to HIV/AIDS, implying that their sexuality education experiences were insufficient with respect to learning about HIV/AIDS.

Stigma manifest through fear, shame, and prejudice.

In describing experiences of school-based sexuality education, participants in the youngest and middle generations described stigma manifesting as fear, shame, and prejudice regarding sexuality and minority sexual identity.

Fear. Participants in the middle and youngest generations discussed fear—both explicit and implicit—as central to their education about sexuality. Fear was explicitly evoked when

discussing the risks involved with sexual behavior, and was implicitly ingrained in lessons about the ethical and moral consequences of engaging in sexual activity. Riley, a White genderqueer person from the middle generation, described the fear elicited from messages about the moral and physical consequences of sexuality:

Things were...super scary, that concept when I was in high school...they do the whole, if you have sex then you go to hell, but it was a lot more back then and the message portrayed throughout sex-ed type things...was, this is going to give you a death sentence.

By teaching that sex was unethical and resulted in a death sentence, sexuality education served to confuse, scare, and stigmatize students. Explicit fear manifested differently across generations, with fear related to pregnancy occurring more frequently in the youngest generation, whereas for the middle generation explicit fear was often described in relation to HIV/AIDS or sexually transmitted infections.

Shame. Across both the middle and youngest generations, shame imbued sexuality education experiences. Given that HIV/AIDS was prominent in sexuality education narratives from the middle generation, shame was often associated with messages received about same-sex sexual behavior leading to disease and death. In the youngest generation, the same notions of shame regarding risky sex persisted, and the historical backdrop of the rise of AOE sexuality education was also evident in how sexual minority young people were taught to feel shame in sexuality education. Jamie, a Black female lesbian from the middle generation, explains how her sexuality education sought to convey that sexuality was shameful:

They taught me that penis and vagina made a baby, and that AIDS will kill you, and all these other diseases that you can have, and here, take this cookie, and you bite off a

piece, and if somebody touches you, you're this broken up ass cookie.... That's what they taught me. That was sex ed.

Prejudice. Prejudice in the form of explicit homophobia was recalled as part of sexuality education among middle and youngest generation participants in our sample. In the middle generation, for example, prejudice was manifested in the conflation of sexual minority identity with disease and moral disapproval. Jason, a White gay male from the middle generation, says: "In Texas, teachers are required to teach that homosexuality is unhealthy and socially unacceptable. That's still part of the curriculum. I don't know if that's gonna change any time soon." Jason describes that explicit prejudice in school-based sexuality education is not only present, but is mandated in certain regions of the United States.

Comparisons of school-based experiences to sexuality education outside of school

Several participants from the youngest generation and one participant from the middle generation explicitly juxtaposed experiences of sexuality education in school with experiences outside of school, such as programs at LGBT community centers and churches. Participants primarily discussed the promotion of knowledge and safety in non-school sexuality education settings, and contrasted these experiences with abstinence-based education in school. For instance, Jane, a multiracial pansexual female from the youngest generation, noted that a church program provided an alternative to her school curriculum: "the church I go to has a very comprehensive sexual education program that starts in fifth and sixth grade, which I hugely appreciate, because our school sex ed was pretty much abstinence based and very, very poor." When discussing what brought them to sexuality education outside of schools, participants described sexual minority inclusivity and diversity. Lola, a Black queer female from the

youngest generation, described feeling accepted and included in conversations surrounding sex and sexuality in a community center outside of school:

Then just being in the [community center], it's not specifically an LGBT place, but at the same time, there was just a diversity of people ... we talked about self-esteem and being a woman. I did a lot of programs where we taught sex Ed and stuff and learned about that, and that made me feel more comfortable about that topic. Cause those conversations never really happened [at school], so I was left to do my own research, and be curious.

In the youngest generation, some SMY sought alternatives to school-based sexuality education, and were able to access sexuality education that was intentionally diverse and inclusive of sexual minority identity—characteristics lacking in their school-based sexuality education classes.

Counter-examples

Although overwhelmingly, participants reported silencing and stigmatizing experiences in school-based sexuality education, counterexamples of our themes also occurred. Val, a Latinx queer genderqueer person from the middle generation, described “sex ed classes that were actually comprehensive...we're talking about gonorrhea and STDs, and we're talking about ‘What does your body do when it menstruates?’ ” Val further describes her sexuality education as providing her with “the whole picture, so I kinda understood that stuff,” implying that Val had the information needed to make informed decisions as they relate to sexual transmitted infections and menstruation. Additionally, Jake, a multiracial gay male from the youngest generation, discussed how receiving comprehensive information helped him understand and validate his identity:

My high school had a sexuality class. While it only touched briefly on different sexualities like gay and bisexual, it kinda was like oh, okay. Then I kinda started to understand more. Then that's why it just happened. I was like that's me. I'm that.

Jake received sexuality education that helped him clarify his identity, likely promoting his health and well-being—the intention of sexuality education as stated by leading public health organizations (Centers for Disease Control and Prevention, 2018).

Discussion

Although research and advocacy regarding the importance of inclusive sexuality education has grown in recent years (Future of Sex Education, 2020), school-based sexuality education in the United States continues to exclude SMY (Elia & Tokunaga, 2015; Kubicek et al., 2010; McNeill, 2013; Santelli et al., 2006; Schalet et al., 2014). In the current study, we analyzed first-hand accounts from sexual minority people coming of age in three distinct generations to understand how rapid social change in both sexuality education and sexual minority visibility shapes sexuality education experiences. In the context of an existing study on minority stress and health, we coded data for narratives regarding school-based sexuality education. Narratives arose in more than one quarter of the sample despite the absence of an explicit question in the interview protocol evoking them. The frequency of sexuality education narratives in our sample suggests that sexuality education experiences are meaningful for sexual minority people. In the face of dramatic social, political, and historical change, three generations of sexual minority people reported that silence, disease, stigma, and exclusion characterized their experiences of school-based sexuality education. These early experiences represent missed opportunities to provide accurate information to sexual minority youth during a critical point of

development. Our findings may shed light on the ways in which current sexuality education practices can become more inclusive of the experiences of SMY.

Four overarching themes emerged with respect to sexuality education experiences: silence, the profound influence of HIV/AIDS, stigma manifest through fear, shame, and prejudice, and comparisons of school-based experiences to sexuality education outside of school. Similarly to prior research (Gowen & Wings-Yanez, 2014; Kubicek et al., 2010; Pingel et al., 2013), silence was the most pervasive theme across generations, revealing the consequences of institutionalized legacies of sexual reticence generally, and the exclusion of sexual minority identity in sexuality education more specifically (Fields, 2008). Despite the prevalence of silence in the narratives of participants across generations, only one participant in the middle generation explicitly discussed an absence of sexuality education experiences. The HIV/AIDS pandemic received significant sustained public attention and was defining for that generation of sexual minority people (Hammack & Cohler, 2011; Hammack, Frost, Meyer, & Pletta, 2018). It also had a profound effect on public investment in sexuality education programs and funding. In fact, sexuality education efforts peaked during that period relative to prior or subsequent generations (Hall, 2017; Santelli et al., 2017); thus, middle generation participants may have been more likely in general to have received some explicit form of school-based sexuality education, and were the first generation to receive fear-based sexuality education that emerged partly in response to the HIV/AIDS crises.

The HIV/AIDS epidemic fundamentally altered both the history of sexual minority visibility and the objectives of sexuality education, and reflections regarding HIV/AIDS content within sexuality education were salient for members of the middle and youngest generations. Although a common focal point in both generations, the middle generation reported HIV/AIDS

as the central way in which they came to define sexual minority identity in sexuality education. Conversely, some in the youngest generation noted the absence of HIV/AIDS information in their school-based sexuality education programs. These narratives from the youngest generation demonstrate that youth expected to learn about HIV/AIDS in sexuality education, possibly because HIV/AIDS has become a salient chapter in youths' master narratives (Hammack & Cohler, 2011) of sexuality and health. Given the prevalence of this theme in our data, sexual minority youth may have internalized HIV/AIDS as connected to sexuality in a different way than their heterosexual peers, as they became aware of same-sex attraction during an era when gay identity was synonymous with death and illness (Hammack et al., 2018).

Participants in the middle and youngest generations reported stigma manifest through fear, shame, and prejudice in their sexuality education courses. Prior research suggests that many in these generations may have received AOE sexuality education, which often weaponizes these themes to develop discourses that frame sexual minority identity in the context of risk (Fisher, 2009; Gowen & Wings-Yanez, 2014; Pingel et al., 2013). In reality, AOE curricula may increase sexual health risk. Those who take abstinence pledges have been found to be less likely to use contraception (Bearman & Brückner, 2001; Rosenbaum, 2009), and to report visiting a doctor for an STI concern (Brückner & Bearman, 2005).

Sexuality education was less frequently mentioned in the oldest generation. Given that these participants were adolescents during the 1970s, when sexuality education was just emerging as a public health concern (McGarry, 1998), this generation may have been less likely to receive sexuality education in school; if they did, it would likely have been focused on pregnancy prevention. When asked what they were afraid of or worried about when they were young, no participants from the oldest generation mentioned sexuality education. Classic fear-

based sexuality education messages emerged in decades after they left secondary schooling, out of panics related to HIV/AIDS. Further, heteronormative messages were not described as part of the sexuality education experiences among those in the oldest generation; it may be that compared to middle and youngest generations, they simply had no expectation to see themselves represented in (hetero)sexuality education.

Finally, those predominantly from the youngest generation compared school-based sexuality education to sexuality education programs outside of school. Given that this generation came of age with the rise of widespread internet exposure that facilitated access to information outside of school, friends, and family, it may not be surprising that these youth reported seeking education programs elsewhere. What's more, prior research on youths' perspectives of school-based sexuality education suggests that many youth perceive that LGBTQ-focused discussions should occur outside of the classroom (Gowen & Wings-Yanez, 2014). Although having access to inclusive sexuality education outside of school is crucial for SMY whose school-based curricula are exclusionary, the task of locating reliable and safe resources outside of classrooms may limit many SMY's access to much-needed sexuality-related information.

Strengths and Limitations

The cohort design of the current study deepens empirical understandings of how sociohistorical contexts are related to sexuality education experiences. Our data was not elicited from a specific prompt and was therefore naturally salient to participants. Our sample was diverse in terms of gender, sexual, and racial/ethnic identities, avoiding biases inherent to demographically homogenous samples. Additionally, the research team was comprised of coders representing diverse genders, sexualities, race/ethnicities, and sociohistorical generations.

Combined with an awareness of the importance of reflexivity in coding, our team explicitly acknowledged our biases through a system of consensual coding.

Our study has several limitations that warrant the need for additional research. First, a question about sexuality education was not written into the interview protocol. As we do not capture data from the entire sample, results may be limited by the larger study's methodology. For example, retrospective bias may have influenced the relatively few excerpts from the oldest generation compared with the middle and youngest generation. Our findings are not intended to be interpreted as representing the experiences of the entire sexual minority population, and future studies should include questions about sexuality education in representative data collection protocols. Additionally, our study is predicated on the idea that distinct sociohistorical generations, defined by cohort-defining events such as the Stonewall Rebellion and the HIV/AIDS epidemic, shaped the lived experiences of participants. Yet, it is hard to know whether our assumptions about the personal importance of such events generalize to all participants in our sample. Future research should examine the centrality of sociohistorical events upon which generations are defined. As this study centered the lives of sexual minority people, there was no non-sexual minority comparison group in our sample, therefore we are unable to determine whether the themes elicited by our sample are specific to sexual minority people. Research moving forward could include a heterosexual comparison group in order to understand the role of sexual identity in experiences of sexuality education. Last, although our sample is demographically diverse, those who self-select into a study of sexual minority lives from four major cities in the U.S. may not represent the experiences of those across distinct socio-economic statuses and levels of urbanicity. Future research should seek to include populations of sexual minority people from rural areas.

Conclusion

In the first study to examine sexual minority peoples' sexuality education experiences across three distinct generations, we found that school-based sexuality education is salient in the lives of sexual minority people into adulthood and across generations. Silence, the lasting shadow of HIV/AIDS, and stigma are relevant to the perpetuation of inequalities that may shape the sexual health behavior and wellbeing of generations of sexual minority people in ways that future research should explore in more detail. Empirical approaches that consider generational contexts when examining sexual health can provide insight into how sexuality education could promote lifelong sexual health and well-being: a central intention of school-based sexuality education.

Since its inception in the United States, the dominant approach to sexuality education has too often been exclusionary and narrowly focused on shifting cultural tides of sexuality-related panics. Inclusive sexuality education policy is needed to stem the sexual health inequalities we see in SMY, and to create a solid foundation for the health and well-being of sexual minority and all youth.

Declaration of Interest

No potential conflict of interest was reported by the authors.

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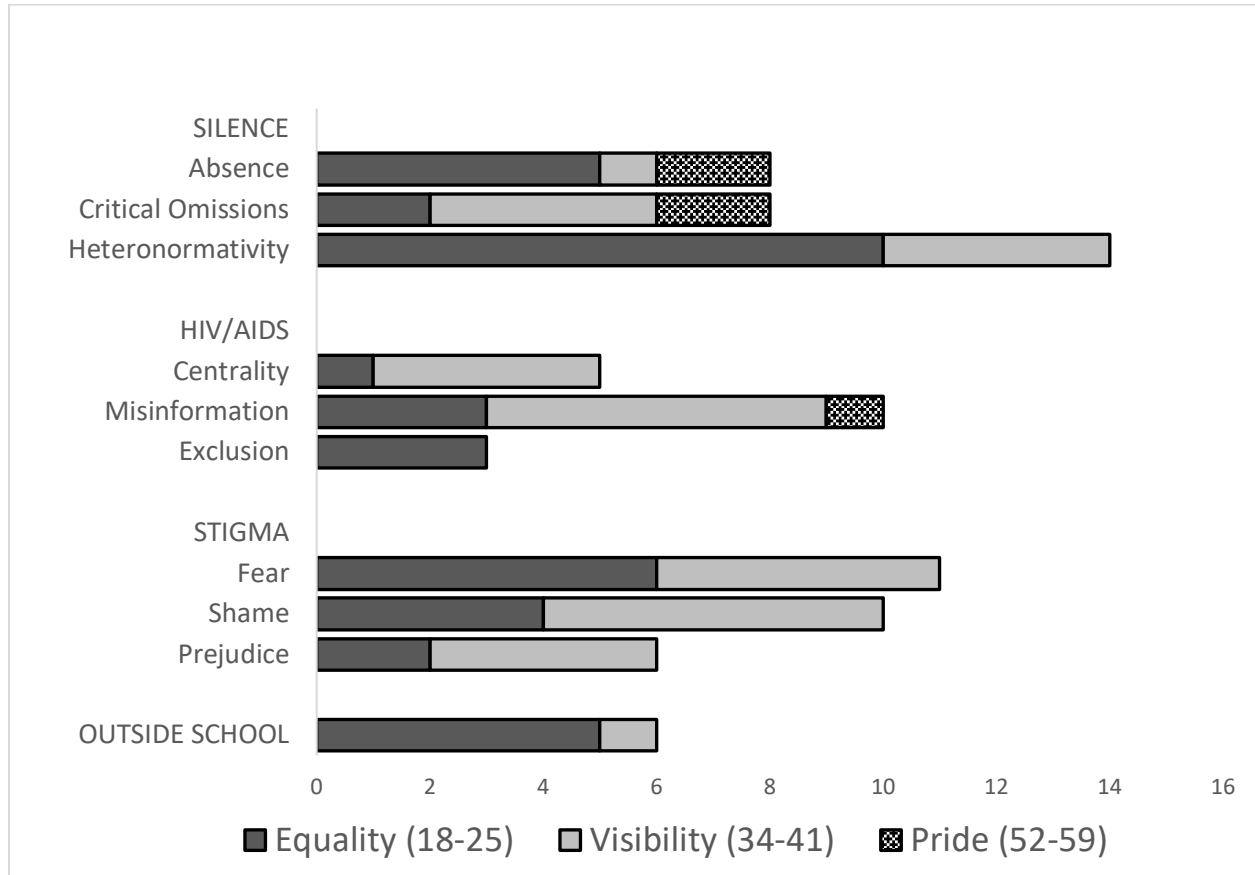
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Table 1. Interviewee Demographics by Generation

	Generation			Total
	Equality	Visibility	Pride	
	Ages 18-25	Ages 34-41	Ages 52-59	
	Secondary School 2000-2015	Secondary School 1984-1999	Secondary School 1966-1981	
	<i>n</i> = 28	<i>n</i> = 18	<i>n</i> = 5	<i>n</i> = 51
<i>Sexual Identity</i>				
Gay/lesbian	13	9	4	26
Bisexual	8	3	0	11
Pansexual	5	0	0	5
Queer	2	6	1	9
<i>Gender Identity</i>				
Male	8	9	2	19
Female	17	6	3	26
Genderqueer	3	3	0	6
<i>Race</i>				
AI	2	3	0	5
API	7	5	0	12
Black	6	2	0	8
Latino	4	4	1	9
Multiracial	6	1	0	7
White	3	3	4	10
<i>Education</i>				
High School	4	0	0	4
Technical/Trade	2	0	0	2
Some College	15	5	1	21
Associates	1	2	2	5
Bachelors	5	1	0	6
Postgraduate	1	10	2	13

Note. Secondary school represents the years during which respondents were likely to attend middle or high school. Data were collected between April 2015- April 2016.

Figure 1. Presence of themes by generation

Note. Frequencies represent the number of respondents who reported the presence of the theme in their interview. Outside school= participants who compared school-based experiences to sexuality education outside of school