

**YOUNG ADULT MALES' EVALUATION OF THEIR SEXUAL HEALTH
EDUCATION: AN ENHANCED CRITICAL INCIDENT TECHNIQUE ANALYSIS**

by

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ABSTRACT

The purpose of this study is to learn from young adult males what critical incidents of sexual health education (SHE) helped, hindered, and were wished for, regarding their personal understanding of their own gender identity and sexuality. With the dramatic disparity in sexual health outcomes between young men and women, it seems sexual health education is not as effective at increasing health seeking behaviours, preventing sexually transmitted diseases, or creating and fostering healthy sexual identity development for males as it is for females.

Using the Enhanced Critical Incident Technique analysis (ECIT) eleven young adult males (ages 18-25) were asked what helped, hindered, and what they wished for from the SHE they received in British Columbia (BC) public schools. This was done to better understand how to better reach males in sexual health education. There was a total of 205 critical incidents (CIs), with 75 helping incidents, 58 hindering incidents, and 72 wish list items (WL). The CIs and WL items are organized into 13 categories that reached the required 25% participation rate (Borgen & Amundson, 1984): five helping categories, two hindering categories, and six wish list categories. The six helping categories are Harm Reduction, Normalization of the Male Body, Condom Demo, Anatomy and Function of Female Body, and Anonymous Question Box. The two hindering categories are Instructor and Delivery and Peer Influence and Behaviour. The six wish list categories are Gender Identity, LGBTQ Inclusive, Class Size, Continuous Education, Sex Positivity and Normalization, and Consent. The resulting data suggests that sexual health education that is continuous, sex-positive, skills-based, and is taught by a normalizing and comfortable instructor in a safe and confidential environment would be most desirable and engaging for young males.

LAY ABSTRACT

This study is interested in how young adult males (ages 18-25) evaluate the sexual health education (sex-ed) they received in BC public schools. Using an enhanced critical incident technique (ECIT) methodology, eleven participants were asked what helped and hindered them in their sexual health education. They were also asked what they wished for from their sexual health education. The goal of the study was to learn how young adult males evaluate their sex-ed so that educators and counsellors can become better informed on how to create and deliver sexual health education that is meaningful and effective for males. The results of this study suggest that sexual health education that starts early and is continuous throughout public school, is sex-positive, skills-based, and taught by a normalizing and comfortable instructor in a safe and confidential environment would be most desirable and engaging for young males.

PREFACE

This thesis is an original, unpublished, independent product of the author, Tymarah Cholewa, who completed all work, including design, participant recruitment, data collection, analysis, and manuscript write-up.

This research received ethics approval from the University of British Columbia's Behavioural Research Ethics Board. The certificate number of the ethics certification obtained for this study was H17-00990, using the project title Young Adult Males Sex-ed.

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CHAPTER 1: INTRODUCTION

1.1 Statement of the Problem

The stark differences between men's and women's health are well documented in existing literature; men have shorter life expectancies, higher rates of suicide, are more likely to have infectious diseases and chronic illness, and are more likely to engage in high-risk behaviours than women. The disparities between men's and women's health increase when looking at young adult populations with sexual health being identified as a specific area of concern (Courtenay, 1998; Davies et al., 2000). The specific needs and interests of young males are not being taken into consideration when designing and implementing sexual health education (SHE) curriculum in British Columbia public schools. This results in SHE content being less engaging and relevant for the students (Byers et al., 2003; Byers, Sears, & Foster, 2013). If young males were being educated about the societal expectations and gender stereotypes that often lead to men not seeking health services, this could help to increase the effectiveness of sexual health education and have positive effects on health outcomes for young men and their partners (Hilton, 2005; Walker, 2001).

Gender is becoming an increasingly relevant issue with the heightened awareness of Western culture being patriarchal and constraining to gender identity development. Women have long been advocating for equal rights to men, and now there is a call to action for equal rights for those who are transgender or non-binary. Feminists most often describe feeling oppressed by the power of patriarchy and the tradition of male dominance and power when they diverge from traditional female social scripts. However, research is beginning to provide increasing evidence that it is actually men and boys, not women and girls, who receive greater societal pressure to

subscribe to, and face graver consequences if they deviate from the traditional gender ideologies of what it means to be a man or a woman (Collumbien & Hawkes, 2000; Courtenay, 2000; Evans, Frank, Oliffe, & Gregory, 2011).

In most Western societies, including Canada, masculinity is most often defined in hegemonic terms – that men should be powerful, assertive, athletic, emotionally stable, and in control. This most often translates into the image of a white, heterosexual, middle-class man who is tough, independent, and doesn't need to seek help from anyone for anything. It is this ideal that men are trying to live up to when they ignore signs of illness, sustain an injury, or are feeling depressed, and avoid seeking medical attention. In order to keep up this manly appearance and to prevent being labelled by others as weak or feminine, men will choose to engage in behaviours such as excessive drinking or drug use, unsafe driving, or high-risk sexual behaviours to prove their masculinity and will restrain from seeking help when they are injured or unwell (Courtenay, 2000; Evans et al., 2011; Robertson, Galdas, & McCreary, 2008).

Health first started to be addressed in terms of gender by feminist scholars in the pursuit of liberating women from socially prescribed female role identities. They pointed out that most health research used men as the standard and very little focus was placed on women's health issues. Discourse around women's health has progressed significantly and deservedly so. It also has spurred attention to gender studies, but it tends to focus on women and other minorities, leaving men's health to still be accounted for. Taking a constructionist and feminist perspective, Courtenay (2000) offers an explanation of how this cycle of hegemonic masculinities continues to persist in men's health. He describes gender as being a “dynamic social structure” where men and women “think and act in the ways that they do, not because of their role identities or psychological traits, but because of concepts about femininity and masculinity that they adopt

from their culture” (p. 1387). From the stance of social constructionism, a theory that suggests we construct our own realities in accordance with the societal expectations we perceive around us, men themselves are responsible for continuing the cycle of hegemonic masculinity; it becomes a self-fulfilling prophecy when men conform to societal expectations of what it means to be a man, reinforcing these expectations to themselves and others.

This issue is compounded even more when society doesn’t acknowledge men’s health concerns or the health differences between men and women. When men do seek health care, physicians ask men fewer questions and give less time for office visits as compared to physician’s office visits with women (Evans et al., 2011). In addition, when men’s health isn’t addressed in research or recognized in institutions such as universities, or when health professionals don’t give the same care to men as women, it only perpetuates the image that men shouldn’t be seeking health care. By excluding men from discussions of health, they remain invisible, and when not seen, it is further expected that it is not necessary. This becomes a dangerous game, as we know men are in need of health care and preventative health care education. Especially for young men, who engage in high-risk behaviours even more so than older men, the need for health promotion, education, and care is crucial (Courtney, 2000; Evans et al., 2011).

In 2007, eight years after Health Canada created the ‘Women’s Health Network’ and the ‘Women’s Health Strategy’ was launched, the Canadian Institutes for Health Research (CIHR), through their Institute of Gender and Health (CIHR-IGH), hosted Canada’s first national conference in men’s health (Robertson et al., 2008). This was the first acknowledgment of the need for health research that was specific to men in Canada and resulted in funding for nine new proposals of men’s health research. While this is progress and a step in the right direction in

terms of focusing on men, Evans et al. (2011) points out that the majority of this new research “is based on sex differences and quantitative rates of difference in illness outcomes for men as compared to women” (p. 8) and fails to include discussion of masculine gender roles in relation to health. Without research that specifically addresses comprehensive health needs, including identity development, it is difficult to know what and where improvements should be made to address these issues of men’s health disparities in a preventative way.

According to Patrick, Covin, Fulop, Calfas, and Lovato, (1997) male college students are more likely than women to engage in 20 out of 26 specific high-risk behaviours. Courtenay (1998) reported that three out of every four deaths among young adults aged 15-24 years old are men. The health differences between men and women between the ages of 18-25 years old are more significant than those between older adult men and women, so much so that the American College Health Association (ACHA) identified young men’s health as their fifth top priority when addressing overall health concerns (Courtenay, 1998).

1.2 Sexual Health Issues

One area that is especially concerning is the area of sexual health. In British Columbia, between 1997 to 2006 the rates of sexually transmitted infections (STI’s) chlamydia and gonorrhoea doubled for young men (Evans et al., 2011). Courtenay (1998) reports that college-age men are more likely to begin sexual activity earlier than women and have more sexual partners. This has serious consequences when we consider that this same demographic is less likely to use condoms when engaging in sexual activity, and is less likely to perceive there being a risk of STI’s or accidental pregnancy. In reality, men under the age of 30 are two and a half times more likely to contract an STI than women of the same age and they are also more likely to

delay seeking treatment of STI symptoms, with the average time of coping with symptoms until seeking medical attention being between two to six months (Courtenay, 1998). There is a dearth in the literature as to why these differences exist, with very little research being conducted on the health-seeking behaviour differences between young adult men and women specifically in sexual health.

In one study conducted by Davies et al. (2000) focus groups consisting of college males discussed their areas of concern around health in general. Seven of the main concerns identified by the men were (listed in order of importance): body image, relationships, STI's, depression, sexuality, peer pressure, and self-confidence. These are all topics that comprehensive sexual health education in primary and secondary schools should be addressing. When asked what the barriers were to accessing more information or health care around these issues, the number one reason the men reported was feeling the need to conceal vulnerability. This demonstrates how living up to the ideals of hegemonic masculinity is more important than seeking out health care and education for young adult males

Studies that examine young adult male perspectives of sexual health education are few and far between. When looking at research on the topic of sexual health, the majority of the literature focuses on health differences between men and women using quantitative methods or just on women and girls. There are some studies that investigate youths' perception of the sexual health education they have received, but they are most often co-ed and done via surveys, limiting room for the emergence of new themes or in-depth personal experience. There is a new arena of educational workshops and programs both in and out of the school system that focus on the areas of concern identified by the males in the Davies et al., (2000) study, but those programs are largely female specific. Very little programming has been developed for males, and even more

rarely are male specific health concerns addressed in co-ed sexual health classes (Tolman, Striepe, & Harmon, 2003).

Theories and frameworks are emerging as to how and why this issue of a lack of male-specific SHE should be evaluated through the lens of gender (Collumbien & Hawkes, 2000; Evans et al., 2011). Traditional gender and social roles are projected onto boys and girls from birth and these stereotyped beliefs about how males and females should act and behave affects not only how SHE is delivered by educators, but also how it is received by students. It has been shown that sexual health education in adolescence and young adulthood improves health outcomes later in life (McKay, Fisher, Maticka-Tyndale, & Barrett, 2001). Expanding the content of the curriculum that is currently being delivered, specifically by adding discussion of gender roles and identity development, provides the opportunity to not only lessen the gap in health differences between genders, but also to increase awareness, tolerance, understanding, and acceptance of all gender identities and lifestyles (McKay et al., 2001; Smylie, Maticka-Tyndale, & Boyd, 2008).

1.3 Need for the Study

With significantly less research and education being focused on the sexual health needs of men and boys than those of women and girls, it is important to consider delivering a curriculum for SHE in schools that is comprehensive and inclusive of all genders (Cupples, Zukoski, & Dierwechter, 2010; Ray, 1998; Saewyc, 2012; Sherrow et al., 2003). It is important that males and females learn about the health concerns specific to all genders as well as the socio-cultural expectations that influence these problems. It is also crucial that teachers, educators, counsellors, and health professionals are aware of these gender disparities and to use

this awareness to inform their practice. It would be beneficial for all if these professionals and experts were to evaluate their own perspectives and values to become aware of any biases they may hold.

There is existing literature and research that explores the identity development of young males, but there is very little that connects the resulting information to sexual health education (Ray, 1998; Walker, 2001). Current literature examines how boys experienced the effects of hegemonic ideals being pushed upon them in their youth, but these discussions tend to be retrospective and not evaluative in terms of the education that was received in school (Courtenay, 2000; Hilton, 2005; Saewyc, 2012). In an extensive literature review, there were no studies found that specifically asked young males for their evaluations of the sexual health education that they had received in a public school system.

There have been studies that have asked students about their perceptions of the quality of the sexual health education they have received, but in addition to school this includes other sources such as parents, siblings, peers, and media (Allen, 2005; Byers et al., 2013; Byers et al., 2003). In addition, these studies are co-ed, using both males and females as participants, and using forced choice surveys rather than open-ended questions and discussion. Hearing from individuals about their personal experience allows for more discovery and a wider variety of experience and perspective.

In order for healthy identity development to be achievable for all genders and identities, traditional social norms need to be addressed with our educators and health professionals, then our youth, so that new generations are equipped with the tools to be accepting of themselves and others and to shed the boundaries created by existing patriarchal and hegemonic ideals. In order to create a comprehensive SHE curriculum that includes addressing the specific needs of males,

research must start with asking boys what is currently working, what needs to be eliminated or revised, and what is missing that they need and want.

1.4 Aim of the Study

The goal of this study is to hear directly from young adult males about what aspects of the sexual health education they received in British Columbia public schools has helped and hindered their personal understanding of their own gender identity and sexuality, and what they wished for in relation to these topics, so that future SHE curricula can address the common needs and interests of boys and young men. Knowing what is most effective in reaching young males can allow teachers, sexual health educators, counsellors, and other health professionals to better create and provide SHE programming that is comprehensive, inclusive, and addresses the social constructions of male and female identity development, hopefully influencing better health outcomes for all persons.

1.5 Overview of the Study

The following chapter will be a review of the literature where the focus will be on the current statistics relating to the sexual health of young adult males, research related to youth's perceptions of sexual health education, and studies specific to sexual health education in Canada. Chapter Three will describe in detail the methodology and research design that was used, including how the data was collected and analyzed. Chapter Four will discuss the findings that resulted from the participant interviews. Finally, Chapter 5 will interpret the findings, draw conclusions, and make recommendations.

CHAPTER 2: REVIEW OF THE LITERATURE

2.1 Introduction to the Literature

Interest in sexual health and the sexual health of young adult males has been increasing over recent years. Although the existing literature tends to cover female-focused or co-ed sexual health education and more quantitative aspects of sexual health outcomes of males, this review will focus on five major themes which emerged throughout the literature reviewed. These themes are: positive health outcomes for males, comprehensive sexual health education programs for males, male experience of sexual health education, educators' perceptions of sexual health education, and youth perceptions of sexual health education in Canada. While the literature presents these themes in a variety of contexts, this review will primarily focus on their application to the lack of comprehensive sexual health education provided in BC public schools and consideration of young males' interests and needs.

2.2 Positive Health Outcomes for Males

In 2014, males aged 20-29 years had the highest chlamydia rates compared to all other age groups and continue to have a rate of chlamydia that is two times greater than that of females (BC Centre for Disease Control, 2015). While the current statistics of sexually transmitted infection (STI) rates and health-seeking behaviours for young adult males are alarming, it is important to acknowledge that how we can create change is much more complex than just administering SHE exclusively on prevention of STI's. Collins and Champion (2009) individually interviewed 14 young men, ages 18-21, asking questions on different facets of male adolescent sexual behaviour. Using a grounded theory design and qualitative approach the

interviewer asked the participants 7 questions. While the purpose of the study was to explore men's perceptions of their role in sexual relationships with adolescent women had a history of STI's, data showed that most of the participants described their SHE to be exclusive to STI and pregnancy prevention (Collins & Champion, 2009).

Education around prevention of STI's and pregnancy are important and it does result in better health outcomes, at least in the short-term. In 2003 Armstrong wrote a special report on The Young Men's Clinic in New York City, an ambulatory clinic specialized in sexual and reproductive health for young men. He closely examined the clinic's history, service model, outreach, funding, and challenges. Based on the clinic's records, Armstrong (2003) reported that increased prevention efforts in the clinic that targeted men in their early 20's did achieve reductions in sexual risk-taking behaviours in the two years after the intervention. This is, of course, very beneficial, but he also noted that health clinics designed specifically for young men are not common, chronically underfunded, often found only in larger urban areas, and tend to not be well attended (Armstrong, 2003).

While infections and unintended pregnancies are important topics to be addressed, Furman and Shaffer, in their chapter on adolescent sexuality in *Adolescent Romantic Relations and Sexual Behavior: Theory, Research, and Practical Implications* (2003), suggest that romantic experiences, relationships, and conventional gender roles should be a focus of SHE. The authors investigated research and theory on identity development in adolescence and reported consistent themes of how gender-related expectations impact young men in early adolescence. They reported that this stage of life is often the period when boys are most expected to adhere to masculine stereotypes and the emergence of dating is one of the most influential factors pressuring young men to conform to gender roles. They suggested that if issues of gender

stereotypes and dating were addressed in school, it could help lessen the pressure and foster opportunity for healthy identity development for both young men and women (Furman & Shaffer, 2003).

Hawkes and Collumbien (2007) overviewed two older studies from South Asia that investigated men's sexual knowledge, attitudes, and behaviours and analyzed the studies qualitative data. In one study from Orissa, India conducted by Weller and Romney (1988), 35 men were asked the structured interview question "what are the sexual health concerns experienced by men in this community?" which when translated into the local language was "what are the problems relating to, or affecting, the genital area?" They were asked this during an interview designed by Weller and Romney (1988) to help inform social marketing of condoms in the area. The second study took place in Bangladesh in 1994 by the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B). The goal of the study was to collect data around the prevalence of STI's for both men and women in the area by administering a qualitative survey.

When Hawkes and Collumbien (2007) analyzed and interpreted selected qualitative data from the two studies they found that how individual's make choices when it comes to sexual behaviours is not just based on factual knowledge from SHE but "is instead nested within a complex range of psycho-social dynamic interactional processes, many of these relating to expectations and feelings, and self-efficacy in interpersonal power relations" (Hawkes & Collumbien, 2007, p. 138). They concluded that understanding one's own sexuality is "the key" (p. 138) to understanding both the sexual and health seeking behaviours that affected men's sexual health. As Furman and Shaffer (2003) pointed out, young boys need to be educated about the social construction of masculinity and how it affects sexual health to provide better

understanding of the self. According to Hawkes and Collumbien (2007) this self-understanding will result in healthier sexual relationships that do not incorporate power disparities based on gender, age, class, or patronage.

2.3 Existing Comprehensive Sexual Health Education Programs for Males

In a report that evaluated a comprehensive sexual health education program designed specifically for young males Cupples, Zukoski, and Dierwechter (2010) found that young men expressed a need to be supported in taking responsibility to cooperate and contribute equally in relationships as well as in overcoming stereotypical gender roles (Cupples et al., 2010). The program, called the MARS Program (Male Advocates for Responsible Sexuality), took place in five counties in Oregon State and was delivered at some high schools, colleges, juvenile detention centers, and faith-based youth groups. The program was designed to be delivered over 6 sessions and addressed topics such as social media, healthy relationships, decision-making, communication, as well as contraception and STIs. The mission of the Mars Program was “to support men in taking a responsible role in promoting equality and cooperation in relationships, pregnancy, and infection prevention, and overcoming stereotypical gender roles” (Cupples et al., 2010, p. 20). Participants (n = 9037) were interviewed via questionnaire after completion of the program, but the article did not give details about the nature of the post-survey that was used. The results showed that 90% of the participants believed the program helped them learn about themselves and their relationships and influenced them to act responsibly in their relationships with others. The program was rated as excellent or good by 82% of participants (Cupples et al., 2010). While this is encouraging in terms of showing that comprehensive sexual health education

is beneficial and effective for males, it again was not part of a school-based program and was shut down due to lack of funding and high staff turnover.

In a similar program that was run out of New York, Man2Man was developed based on Bandura's Social Learning Theory (Sherrow et al., 2003). The program used all male facilitators to bring a comprehensive SHE program to high school aged males out of a private space and outside of school time. The program's developers believed in the Theory of Reasoned Action: "behavioural intent and action are influenced by two important factors: one's attitude toward the positive and negative aspects of a particular behaviour, and one's perceptions of social norms and what others think about engaging in that behaviour" (Sherrow et al., 2003, p. 215). The goals of the program were to increase young men's awareness of men's health issues, sexual behaviours, personal values and identity, and responsible relationships. Sherrow et al. (2003) wrote a report on Man2Man but unfortunately did not provide the exact number of participants who provided the feedback or how they obtained the feedback. Participants acknowledged that the content was helpful and that they liked being in small groups that created a safe space for sharing and self-disclosure. However, the participants expressed a need for more information around relationships with women, communication, and indicated that they would like a better understanding of women's issues, relationship expectations, and "manhood and responsibility" (Sherrow et al., 2003). Again, this program attempted to deliver comprehensive SHE, but when private organizations can only provide a limited amount of content due to time constraints, funding, and staff, not all issues and topics that are pertinent can be addressed. This is another reason why comprehensive SHE is so important to be delivered consistently, year after year, in the school system.

2.4 Male Experience of Sexual Health Education

It is helpful that previous research investigating male identity development has been able to identify topics of concern and make recommendations of issues that should be incorporated into future SHE curricula. It is also encouraging to know that there have been programs piloted that show comprehensive SHE programs designed specifically for males can be effective.

Unfortunately, these programs are not very feasible in terms of longevity, financial stability, and reaching a wide population. Male sexual health is beginning to gain the attention it deserves, but more work needs to be done, especially around school-based SHE.

Tolman, Striepe, and Harmon (2003) began developing a model of adolescent sexual health that was focused around gender identity discourse and how it is organized by patriarchy. They wanted to tailor a program specifically for young girls to help them critically think about their gender identity development from a social constructionist and feminist point of view, integrating examination of “how patriarchal ideologies...regulate and police girls’ sexuality” (p. 7). However, as they started working with female adolescents in a co-ed classroom, they were challenged by school personnel around the ethics and practicalities of excluding males. To be inclusive Tolman et al., (2003) decided to also interview the male students. They used a narrative analysis approach called the Listening Guide which was intended to help the male student feel included. The purpose of the male student interviews was to use the male perspective to design the education program for the girls. The researchers were surprised to find that the boys’ sexual health concerns overlapped significantly with those of the girls’ stating, “men and boys encounter discourses and pressures to behave as acceptable heterosexual males that are comparable and complementary to the discourses and pressures encountered by women and girls” (p. 10). Ultimately, Tolman et al., (2003) decided to completely revise their model to

include both males and females with focus being placed equally on the specific needs of each gender. The article did not provide the sample size of participants.

This study shows the inherent bias that educators, researchers, and other health professionals can hold. Tolman et al. (2003) hadn't considered the impact of patriarchy on boys, and instead assumed that girls were the ones who needed specialized education for them to have healthy identity development. This is a perfect example of the cycle of hegemonic masculinity in education and healthcare; it is assumed by authority figures that boys are not impacted by societal expectations in the same way girls are so it is simply not addressed. When dialogue on identity and sexual health is openly encouraged and offered to girls, but excludes boys, it reinforces the notion that young men shouldn't need or ask for help. Tolman and colleagues (2003) recognized their mistake with the help of mindful school faculty, and hopefully their new path of research will contribute to more comprehensive and inclusive SHE.

Over the course of a two-year project, Ray (1998) consulted with boys aged 5-16 years old about their sexual identity and where they received their sexual health education. She does not report the exact number of boys with which she conducted the consultations in her article. What she found was that boys expressed feeling a strong pressure to "present as 'hard', 'strong', and as if 'they know it all'". They shared with her a fear of being bullied if they didn't present themselves in adherence with hegemonic standards and so engaged in bullying others, using homophobia, macho posturing, and disruptiveness at school, especially when engaged in conversations around sex and sexuality. From her interviews, Ray (1998) found that boys reported receiving most of their SHE from peers, not from parents or at school. This is problematic because boys described needing to demonstrate masculine ideals the most when they are with peers. Ray's (1998) results give the impression that boys grow up feeling alienated and

alone; they want to learn about sex and sexuality they are not receiving it at home or at school, and when they are with peers, they feel the need to act like they already know everything and feel unable to ask questions.

Studies by Hilton (2005) and Walker (2001) had similar findings. Hilton administered questionnaires to 313 boys aged 16-17 years and ran three focus groups with eight boys per group. Participants were asked about their sources of information for sex and sexuality. The young men reported feeling the need to stress their heterosexuality and masculinity the most while in SHE classes, being disruptive and making fun of others. Participants expressed genuine fear of being accused of being gay and being humiliated by peers if they were to seriously bring up sex or relationships in conversation. Instead of paying attention in their SHE classes or discussing with friends, they reported pornography as their main source of information about women and sex. A common theme that emerged from the focus groups was feeling the expectation to know what to do when it came to sexual activity, yet never being taught or told about the actual mechanics of sex or how to give pleasure to a partner (Hilton, 2005). Walker (2001) ran a very similar study that confirmed boys experience emotional isolation in SHE classes because of peer expectation and so he suggested that policy-makers and implementers of SHE should gain a better understanding of boys' gender identity development "to support and develop curricula for more relevant and personal education" (p. 124). Walker (2001) used semi-structured individual and group interviews and direct observations, plus focus group workshops but did not report the sample size of his study in his article.

The Davies et al. (2000) study mentioned in the first chapter of this study is one of the more comprehensive studies done on male sexual health needs, although the purpose of the study was to focus on general health. Davies and colleagues (2000) acquired a representative sample

(n=49) that reflected a cross-sample of male college students. The participants were placed into small focus groups that ran for 75 minutes with three to seven members per group. There were five main questions that asked about general health concerns that were used as discussion topics. The results showed these college-aged men were most concerned with topics that should all be a part of comprehensive SHE and relate to identity development. Body image, relationships, STI's, depression, sexuality, peer pressure, and self-confidence were the top seven concerns reported by the participants. The group members also shared that it was the need to appear strong and the pressure to maintain an image of not needing to seek information or help that prevented them from exploring these areas either with peers or professionals (Davies et al., 2000).

Given that young boys are so nervous about expressing their desire for knowledge around sex and sexuality, and feel the need to demonstrate masculine norms when the topic is being addressed in classes, it is surprising to learn of their openness and vulnerability when in small focus groups. In the study by Davies et al., (2000), participants engage and go into great detail, showing emotional depth. This demonstration of vulnerability and openness is a trend that shows consistently in research on topics of male sexual health when the participants are interviewed individually or are in single-sex focus groups, but this same openness is absent when participants are in mixed-sex groups (Armstrong, 2003; Collins & Champion, 2009; Cupples et al., 2010; Mckay & Holowaty, 1997; Ray, 1998; Saewyc, 2012; Sherrow et al., 2003; Walker, 2001). This trend depicts the need felt by male youth for connection, learning, and self-understanding. The desire to learn is there, but gender expectations enforce the repression of expressing their needs and desires.

2.5 Educators Perceptions of Sexual Health Education

In addition to her consultations with boys, Ray (1998) also surveyed 130 sex educators about their perceptions of current sexual health education via questionnaire. The major theme that came out of the questionnaires was that educators believe that SHE content needs to address the needs and interests of the students, boys in particular. They expressed that they felt most school teachers were not well equipped to provide SHE and should undergo specific training before teaching SHE. It was also suggested that lessons need to be more practical, and less factual. For example, students should be learning “how” to put on a condom, not “why” to put on a condom. Overall the results from Ray’s work (1998) suggest that boys are being left behind in the classroom when it comes to SHE, that schools need to address what boys and girls want to be taught – what is most pertinent to them at that specific point in time, and that trained teachers make a safe space where practical, skill-based lessons can be taught.

2.6 Sexual Health Education in Canada

In Canada, the public school system is the primary source of SHE (Byers et al., 2003) and the federal government has guidelines and recommendations that can be found in the Canadian Guidelines for Sexual Health Education (2003) created by the Public Health Agency of Canada. It outlines and provides a checklist for sexual health topics that need to be addressed in each grade, however these programs vary province to province, school to school, and class to class. In British Columbia, the Ministry of Education has its own specific prescribed learning outcomes. The most recent guidelines set for BC can be found in the Health and Career Education K to 7: Integrated Resource Package 2006, Health and Career Education 8 and 9: Integrated Resource Package 2005, Planning 10: Integrated Resource Package 2007, and Career and Personal

Planning 11 and 12, 1997. Teachers and sexual health experts agree that not all of the required topics are always included (Byers et al., 2013; Byers et al., 2003).

Byers et al. (2003) describe most Canadian SHE curriculum as being designed based on adult views and concerns, but that it would be more successful if the perspectives of adolescents were used to design the curriculum instead. In their study where they administered surveys to 740 middle-school students and 1,663 high school students in New Brunswick, they found that students were less than happy with the SHE they were receiving in school. The study's results are expanded upon in the following section. In their 1997 research McKay and Holowaty found that the SHE in Canada was primarily focused on anatomy and biological aspects of reproductive health and that teachers were often unprepared and uncomfortable when it came to teaching sexual health topics. McKay and Holowaty (1997) surveyed 406 Ontario adolescents in grades 7-12 and found that they described their SHE as "boring and repetitive" and that it "lacked personal relevancy" (p.2).

2.7 Research Questions

In a review of the literature, only 3 studies could be found that asked Canadian youth (both males and females) what their perceptions were of the SHE they had received at school (Byers et al., 2013; Byers et al., 2003; McKay & Holowaty, 1997). These three studies all have consistent results - that students agree receiving SHE in school is their main source of sexual health knowledge, it is important and desired, but that they are overall dissatisfied with the current SHE provision and content. In Byers et al., (2003) study, 55% of the 1,663 high school student participants and nearly one third of the middle school students rated their SHE as poor, and nearly 75% of high school participants said that topics they were interested in or felt were

relevant were not covered. In 2013 Byers et al. surveyed 478 middle-school students in New Brunswick with a focus on the student's perceptions of the delivery and content of the SHE they had received. The results showed that participants rated the quality of their SHE higher when they perceived their teacher to be comfortable with the topics and more open to answering their questions. Participants who rated their overall satisfaction with their SHE as low also tended to rate their teachers as less effective (Byers et al., 2013). In all three studies, when asked what kind of topics they did want to be covered, the main themes identified were practical skills and values clarification, such as discussion-based conversations on relationships, communication, and how-to skills such as putting on a condom or giving pleasure (Byers et al., 2013; Byers et al., 2003; McKay & Holowaty, 1997). These types of topics are what contribute to comprehensive SHE and contributed to better health outcomes in the community-based programs. Byers et al. (2013) also pointed out that school-based sexual health education tends to be directed more to girls than boys.

Research specific to what is meaningful, irrelevant, and desired by males is merited so that positive and improved identity development and sexual health outcomes can be had by all. According to the existing literature, SHE will be most effective when topics of interest identified by those receiving it will be addressed (Ray, 1998). Additionally, studies show that SHE that is interesting and engaging for the students will improve health outcomes in the future (Armstrong, 2003; Byers et al., 2003). The aforementioned studies have begun to examine students' perceptions of SHE more generally, and to recognize the need for comprehensive SHE for males, but none have yet looked at the SHE in British Columbia. More specifically, there is not yet a study that examines young adult males' perceptions of SHE and how it relates to identity development, social expectations of male gender roles, and personal understanding of sexuality.

In order to develop comprehensive SHE that is effective and meaningful, we need to first ask young adult males what is already working, what needs to be eliminated, and what is missing in the school-based SHE they received. Their input will be the stepping stone to learning and identifying what males are needing and when they need it to optimize healthy identity development and personal understanding of sexuality. How can we maximize effectiveness of SHE for boys so that they can understand themselves and better critically think about their personal values, beliefs and judgments which will hopefully result in better understanding and fairness for all genders and identities? Regarding their personal understanding of gender role expectations, identity development and sexuality, this proposed study asks the following questions: (a) “What did young adult males find helpful in the sexual health education they received in BC public schools?”, (b) “What did they find unhelpful?”, and (c) “What would have been helpful to them if it had been included in the curriculum?” The hope is that the answers can contribute to more effective SHE curriculum in BC in the future.

CHAPTER 3: RESEARCH METHODOLOGY

This chapter outlines the research method and procedures that I used to conduct this study. I will begin by discussing why the enhanced critical incident technique (ECIT) was used to understand the research question: “What are young adult males’ evaluations of the sexual health education they have received in primary and/or secondary school, specifically around sexual and gender identity, in terms of what helped, hindered, and what they wished for?” I will then describe how participants were recruited and selected, the procedure for data collection, data analysis, as well as rigour and ethical considerations.

3.1 Research Design

Enhanced Critical Incident Technique. In this research, the Enhanced Critical Incident Technique was used by incorporating into the CIT model the use of credibility checks, adding contextual information to initial interview questions, and wish list items (Butterfield et al., 2009). The aim of a CIT study is to uncover “effective and ineffective ways of doing something” by identifying “helping and hindering factors, collecting functional or behavioural descriptions of events or problems, examining success or failure, and determining characteristics that are critical to important aspects of an activity or event” (Butterfield et al., 2005, p.476). In this study, the “activity or event” would be the delivery of sexual health education in BC public schools and its influence on identity development and personal understanding of sexuality for young men. Because this study is exploratory in nature, as well as the fact that there is a dearth of literature in this area, ECIT will be especially appropriate as it can assist in identifying turning points and specific qualities that can inform the building of future theories or models of sexual health education (SHE) curriculum for young males by asking participants about what they wished for

in their sexual health education (Butterfield et al., 2009). What is impactful and can influence males to reflect on gender role expectations and identity development, health-seeking behaviours, and better decision-making when it comes to sexuality, relationships, and communication is a research topic that is still relatively unexplored. There is even less understanding of what impedes young men in these areas. An ECIT study that specifically asks what is helpful, what hinders, and what would have helped can help to answer questions about factors that are most impactful, influential, redundant, or are missing. Thus, the purpose of this study is to learn what aspects of the BC public school sexual health education curriculum young men found helped, hindered, and what they wished for in the curriculum that addressed their personal understanding of their gender identity and sexuality.

3.2 Participants

Participant recruitment and selection. This research is an ECIT study that focuses on young adult males. Participants were recruited purposefully through posters on university and college campuses in the lower mainland, social media posts, such as Facebook and Craigslist, and through word of mouth. They were also recruited through convenience sampling from courses at Douglas College where instructors agreed to ask students if they would be willing to be contacted for possible research participation. Those students were then sent a recruitment poster via the email address they provided on the voluntary sign-up sheet. Participants then consented to an initial interview that asked them about their sexual health education experience, specifically what helped, hindered, and what they wished for as well as one email post-interview. The email's purpose was to ask any needed follow up questions and allow the participants to ensure accuracy of the data. They were provided with a consent form that explains the purpose of

the research, describes procedural protection of anonymity, indicates that they will not be required to provide their names for publication, and explains they can withdraw their consent and end their participation at any point in time. Typically, 10-15 participants are needed in an ECIT study before no new critical incidents or wish list items are identified and no new categories are required, signaling data exhaustiveness. In this study, exhaustiveness was reached after 9 participants, and two more participants were interviewed to ensure saturation of data.

To participate in the study, participants had to self-identify as male, as having received sexual health education in the BC public school system at some point in primary, middle, or high school, and be 18-25 years of age.

All participants were given a \$25 gift certificate as compensation for their participation in the study.

Participant Demographics. The demographics of the participants are as follows: One participant was 18 years of age, two were 19, three were 20, two were 21, one was 22, and two were 25 years of age. Nine participants had completed some post-secondary education, and two participants had completed a bachelor's degree. Two participants were unemployed, six were employed part-time, and three were employed full-time. Eight of the participants identified their sexual orientation as straight, two participants identified as gay, and one participant identified as bisexual. Finally, four participants identified their race/ethnicity as Caucasian, three participants identified as Chinese-Canadian, one participant identified as Metis, one participant identified as Polish, one participant identified as Filipino, and one participant identified as Indian/South Asian. All participants were either born in Canada or had moved to Canada at an early age.

3.3 Data Collection

The researcher conducted one-on-one interviews using a semi-formal interview schedule with 11 participants, once with each participant, as well as a second follow-up contact via email. The interviews were conducted over the period of May – June 2017 either in person on the UBC Point Grey campus at the Psychoeducational Research and Training Centre or via FaceTime.

Interviews were conducted after the participant had been given an informed consent form, the researcher explained it, the participant had the opportunity to ask questions, and then signed it. Interviews had an average duration of 50 minutes in length. In the interviews, participants described in detail when they received sexual health education, the duration of the education, what topics were covered, how has it impacted, helped and hindered their sexual health and identity development, relationships, and health-seeking behaviours, as well as what they wished for. At the end of the interview participants were asked demographic data. The interviews were followed by a second contact via email for the participant checking and validating the main categories developed from the first interview.

Interviews were audio-recorded. Observer notes were made during all interviews and used as a means of collecting data. These notes included details of body language, emotional expression, and attitudes. The notes were used to provide clarification to the interview transcripts. All audiotapes, transcripts, and notes were stored in a lockable cabinet in the researcher's home. Each participant was assigned an identity code to protect their anonymity. Demographic information was kept separately from the interview data.

3.4 Data Analysis

ECIT has a protocol on how to organize and analyze data that was followed: organizing the raw data, identifying the critical incidents (CIs) and wish list (WL) items, and creating the categories (Butterfield et al., 2009). The interviews were transcribed into text documents. The frame of reference for the data analysis was that the researcher would like to use the results to inform future SHE curriculum. The CIs and WL items were extracted from the data in batches of three randomly chosen interviews (Butterfield et al., 2009). Helping CI's were then identified in each interview, followed by hindering CI's, then WL items. To be identified as a CI or WL item there needed to be examples that describe the characteristic and its importance in relation to the frame of reference. Categories were then created for each CI (helping, hindering, and WL) based on recurrent themes. For example, if one participant repeatedly identifies different helping CI's that all have to do with how the content being delivered via video, they could be grouped together under the category "video content". Each category was named and given an operational definition. For a category to be considered viable, at least 25% of participants must identify with the CI (Borgen & Amundson, 1984). The established categories are discussed in the following chapter.

Data interpretation included the nine credibility checks that are a part of the ECIT method: audiotaping interviews, interview fidelity, independent extraction of CIs and WL items, exhaustiveness, participation rates, placing incidents into categories by an independent judge, cross-checking by participants, expert opinions, and theoretical agreement (Butterfield et al., 2009).

3.5 Trustworthiness and Rigour

Trustworthiness and rigour were established through the nine credibility checks that are essential to using the Enhanced Critical Incident Technique (Butterfield et al., 2005).

Audiotaping. Interviews were audio-recorded in order to accurately document the participants' words and stories. Audio-recordings were transcribed verbatim by the researcher or by a professional transcriber after signing a confidentiality agreement.

Interview Fidelity. 25 percent of the interview transcripts, chosen at random, were reviewed by an independent judge who was familiar with ECIT methodology. This was done to ensure that the researcher followed the interview protocol and to ensure no leading questions were asked. The independent judge had no objections or concerns.

Independent extraction of CIs and WL items. A coder independently extracted CIs and WL items from 25% of the interview transcripts. This 25% was randomly selected. This was done to ensure the independent coder agrees with the CIs and WL items the researcher identified. The independent code checker was a peer who offered their time in exchange for my time as an independent code checker for their own research. There was 100% agreement between what the researcher and the coder identified as critical incidents or wish list items.

Exhaustiveness. Categories of CIs and WL items were logged to track exhaustiveness. Exhaustiveness is considered to be achieved when no new categories emerge for the data. Adhering to the ECIT method, 10% of interviews were held back from data analysis, and then analyzed after completion of the other 90% of interviews, to see if the resulting CI's and WL items fit into the existing categories and that no new themes emerged. According to this ECIT standard, exhaustiveness was reached in this study.

Participation rates. As per the criteria set by Borgen and Amundson (1984) 25% of participants must identify with the CI or WL item to be considered credible. Table 1 in the Findings Chapter reports the participation rates calculated for each category.

Placing incidents into categories by an independent judge. An independent judge was given a random 25% of the CIs and WL items that were identified by the researcher. Each CI and WL item was then placed into existing categories by the independent judge. The initial agreement rate between the researcher and independent judge was 91%. After discussion of the CIs and WL items that were categorized differently, and after clarification of the category operational definitions, the researcher and independent judge were in 100% agreement.

Cross-checking by participants. After the initial interview, each participant received a follow-up email summarizing the identified CI and WL items that were extracted from his interview. Categories and definitions were also included. Ten out of eleven participants replied to the follow-up email, with one participant offering one minor revision to a CI which was then revised in the analysis by the researcher. The ten participants who replied to the follow-up email all stated that they agreed with the researcher's summaries and the categorization of their CIs and WL items. This check was done last, after consulting with experts about categories.

Expert opinions. Two experts in the field of sexual health education and reproductive counselling reviewed the identified categories. One of the experts has a BSW and has worked as a sexual health educator and reproductive health counsellor for over 25 years. The other expert has an MA in Counselling Psychology and is a registered clinical counsellor who has been working as a sexual health educator and reproductive health counsellor for the past 3 years. After discussion, slight revisions were made to category names based on the experts' input.

Theoretical agreement. Categories that emerged from the resulting data are compared to relevant scholarly literature in the Discussion chapter.

3.6 Role of the Researcher/Researcher's Subjective Stance

I received limited sexual health education as I attended primary and secondary school but in grade 5 had a teacher who taught comprehensive sexual health education that was incredibly valuable to me. This inspired me to pursue work in this field. I was trained and certified as a sexual health educator in 2012. I worked in the lower mainland as a sexual health educator in primary and secondary schools, as well as facilitated workshops for adults and other healthcare professionals on how to talk with children and young adults about sex and sexuality. I continue to facilitate workshops and train faculty at the post-secondary level on sexual health topics and issues. I am aware of the requirements set by the Ministry of Education of what should be taught in each grade as part of sexual health education, and am also aware of how rarely these standards are met. It is through this personal and professional lens that I am engaged in this prospective study, with my core belief that comprehensive sexual health education is necessary and invaluable to young people to help them with identity development and personal relationships.

3.7 Data Presentation

The data is presented through the established categories that represent the larger meaning of the data. Categories are presented in the following Findings chapter.

3.8 Ethics

Strict research protocols implemented by UBC's Behavioural Research Ethics Board were followed and the researcher adhered to a strict code of ethics. This study is considered minimal risk according to the UBC Research Ethics Board definition.

3.9 Dissemination of Research Findings

The resulting data will add to the breadth of the literature that is lacking in this area. In addition, researchers will be better able to isolate variables and develop models about education and counselling for this specific population. Health professionals, educators, and counsellors can use the resulting data to develop and plan interventions, programs, and curriculum that meet the needs of young males. When in practice, these materials could potentially increase young males' self-awareness, positive health-seeking behaviours, and benefit their future relationships.

CHAPTER 4: FINDINGS

Eleven participants were interviewed for this study. From these interviews, there was a total of 205 critical incidents (CIs) and wish list (WL) items that were extracted. There were 75 incidents that the participants found to be helpful in cultivating understanding of their own personal gender identity and/or sexuality and sexual health, 58 incidents that they found to be hindering, and 72 wish list items that they thought would have been helpful had they been provided in their sexual health education classes. The CIs and WL items are organized into 20 categories: there are 6 helping categories, 5 hindering categories, and 9 wish list categories. Table 1 displays the organization of these CIs and WL items into their respective categories. As per the 25% participation rate criteria set by Borgen and Amundson (1984), only the findings from the categories that achieve this rate or higher will be discussed in this chapter. These findings are bolded in Table 1. For the categories that did not achieve the 25% participation rate, they are displayed unbolded in Table 1 and rather than being discussed in this chapter, they are detailed in Appendix G.

This chapter will begin by reporting the findings that resulted from the contextual questions that were asked at the beginning of the participant interviews, including general information about the sexual health education they received (i.e., what grade, duration, class size, instructor, content), their interpretation of the terms sexual health education, gender identity, and sexuality, and if they consider themselves to have a low, moderate, or high understanding of their gender identity, sexuality, and sexual health. Following the contextual findings, the critical incidents and wish list items in the helping, hindering, and wish list categories will be reported.

Table 1. Helping, Hindering, and Wish List Categories

Category	HELPING			HINDERING			WISH LIST		
	Participants	Participation Rate (PR)	Incidents	Participants	PR	Incidents	Participants	PR	Incidents
HELPING									
Harm Reduction	6	55%	16	4	36%	5	6	55%	10
Normalization of Male Body	6	55%	14	0	0	0	5	45%	7
Condom Demo	5	45%	5	0	0	0	0	0	0
Anatomy & Function of Female Body	4	36%	4	1	9%	1	0	0	0
Anonymous Question Box	3	27%	6	0	0	0	2	18%	2
Healthy Relationships	1	9%	1	0	0	0	0	0	0
HINDERING									
Instructor and Delivery	6	55%	25	10	91%	19	7	64%	8
Peer Influence & Behaviour	0	0	0	8	73%	10	0	0	0
Separated by Gender	0	0	0	2	18%	2	2	18%	2
Readiness	0	0	0	1	9%	1	0	0	0
Lack of Resources	0	0	0	1	9%	1	0	0	0
WISH LIST									
Gender Identity	0	0	0	0	0	0	9	82%	10
LGBTQ Inclusive	0	0	0	5	45%	11	6	55%	8
Class Size	0	0	0	4	36%	4	5	45%	5
Continuous Education	1	9%	1	4	36%	4	4	36%	8
Sex Positivity & Normalization	0	0	0	0	0	0	4	36%	4
Consent	0	0	0	0	0	0	3	27%	3
Social Media & Critical Thinking	1	9%	3	0	0	0	2	18%	2
Pornography	0	0	0	0	0	0	2	18%	2
"How-To"	0	0	0	0	0	0	1	9%	1

*Categories that achieved the minimum 25% participation rate are displayed bolded. Categories that did not achieve the 25% participation rate are displayed unbolded.

4.1 Contextual Findings

All 11 participants answered the contextual questions in the interviews, contributing to the findings reported here. Participants were asked about the sexual health education they received in BC public school and what the terms “sexual health education,” “gender identity,” and “sexuality” mean to them. They were also asked both pre- and post-interview to rate their personal understanding of their own gender identity, sexuality, and sexual health on a scale of 0-10 where 0 is a poor understanding, 5 is moderate, and 10 is a high understanding.

Sexual health education received by Participants. At the beginning of the interview, as a way of getting started, the participants were asked to tell the interviewer about the sexual health education they had received in a BC public school.

Three of the participants had only ever had one sexual health education class throughout all their public schooling; one of these participants had had one class in grade four, another had one in grade six, and the other had one sex-ed class in grade 9. Two of the participants had received a series of sex-ed classes but in one grade only; one participant explained he had received a series of five sex-ed classes in grade 10 as part of the required Planning course set by the BC Ministry of Education, and the other participant recalled having six sex-ed classes over a six-week period in grade six. Four participants said they had received two sex-ed classes over their public school career, with each individual class happening in a different grade. All four of these participants received these two classes between grades six to ten. Lastly, two of the participants reported having had three individual sex-ed classes, each in a different grade, having had received them between grades four to ten.

Four of the eleven participants reported that students were separated by gender in at least one of their sex-ed classes. When asked about who taught the sex-ed classes, there was a

variance from class to class, grade to grade, of the instructor being either the regular classroom teacher, another staff member from the school such as a librarian, gym teacher, or school nurse, or a guest instructor from outside of the school. Individual sex-ed classes ranged in length from 30-90 minutes. Some of the classes were reported by participants as being taught to their regular classroom only, while others described being placed in large groups where all the classes from one grade, or even from two grades, came together for the lesson. Sexually transmitted infections, pregnancy prevention, anatomy, puberty, reproduction, and healthy relationships were the topics reported by participants as being covered in the sexual health education classes they received.

Interpretation of the term “sexual health education.” Participants were asked what the term “sexual health education” means to them. Participants described sexual health education as meaning “learning about sexuality across the lifespan,” “debunking myths,” “giving kids knowledge and confidence,” and “preparing young people to be sexual beings.”

All eleven participants included learning about how to have safe sex and how to make informed decisions when it came to sexual activity in their interpretation of sexual health education. To many of the participants this meant a harm reduction approach, where the discussion about sex is framed in a sex-positive and normalizing way. It “shouldn’t be to instill a bit of fear” but rather to enforce “how it’s healthy.” As one participant described:

It means preparing people who are in the middle of growing up to experience sex for themselves in a way where they know what's going on, they won't harm themselves either by, like, having a baby or physically harming themselves . . . And afterwards, making sex like less of a taboo topic, so they can actually discuss it with like the sex-ed teacher or other teachers or their parents about what happened, about what they're feeling.

The other common theme that arose from this contextual question was how sex-ed meant having the opportunity to learn about other lifestyles, orientations, and genders. There seemed to be a consensus among participants that promoting open, accepting, and inclusive attitudes towards not only one's own sexuality, but the sexuality and identity of others, was very important, "especially nowadays." One participant stated that:

To me [sexual health education] means giving knowledge to youth who are growing up in a very sexualized environment. About teaching them the proper – proper conduct to when – when dealing with people of opposite genders or just genders period. You know, about how to deal with sexuality. I feel like that's something that's very lacking nowadays.

Other participants focused on the language and "sexual terms" that refer to other orientations and genders, saying that "it's 2017," "it's more strict because the world is more gender-open now." One of the participants explained that he believes when it comes to interacting with others who identify differently than oneself "sex-ed is all about giving kids the use, the knowledge and the confidence to be in a situation and know how to handle it and what to do with it."

Interpretation of the term "gender identity." Participants were asked what the term gender identity means to them. Most of the participants felt unsure about how to answer this question, and often asked for the question to be rephrased or to be given an example. When asked, the interviewer would rephrase the question as "how would you define the term gender identity?" No examples of how to respond to the question were given to participants. It was always stressed to the participants that there was no right or wrong answer to the question. Some of the terms used by participants to describe their own personal understanding of gender identity were "the way you were raised," "personal interests," "what your role is," and "pronoun usage."

Most of the participants seemed perplexed and had a hard time articulating their answers, with one participant saying:

I think for me, I actually didn't have much education on that, which I think is something that needs to be improved. From what I have gleaned through social media as well as friends who are advocates of I guess education on gender identity, it's - I guess it's more of educating, I guess, young people to understand that, I guess, gender and gender identity is something that isn't black and white or rather across a spectrum. I think that's a fairly, I guess, new idea to the general public. The fact that I can't say much about it means that there is a lack of education. So as much as I can't say a lot about it, the fact that I can't say a lot about it says a lot.

Others had a general idea of what it meant to them. One participant simply stated, "Gender identity. Just knowing what your role is. As a guy you're supposed to be sort of – what we're told, the more dominant one," while another participant explained, "That's not something I've put a lot of thought in...growing up...it was the idea, you know, macho man, feminine man."

Three participants connected their personal understanding of gender identity to how they relate to others in terms of personal interests and relationships. When talking about it with the interviewer, these participants were quite reflective on identity development in general. One participant discussed how he understands his own gender identity development:

I think when it comes to gender identity, I guess it means to kind of understand why I act the way I do in the sense of how I've been brought up like male and how that can affect my perception of other people and even understanding of my own strengths and which emotions I can use and - yeah. Just kind of understanding how I interact with other people.

Another participant also reflected on how an individual may cultivate understanding of gender identity by looking to the types of activities and the people a person feels connected to:

Well it's more like understanding what you like to do. Like not looking at it as males or females. Look at it as interests. If you're interested in building things or computers or whatever, do that. Go - go out into the real world and like interact with people. The way to find out who they really are is once you start talking to people you realize who you're comfortable around and who you're not comfortable around.

This idea of cultivating a personal understanding of gender identity through personal relationships continued to be shared among other participants. Another participant stated, “I guess it varies per person. Like the definition, like what it means to them, but for me personally it's just, you know, like who I am and I guess like how I connect - like I relate with other people.” This idea of letting oneself follow their interests as a way of learning how to self-identify is a very intuitive approach. Being in tune with one’s feelings, where one feels most comfortable and who they feel most comfortable with, is a sentiment echoed by another participant who believes gender identity comes from a sense of internal feeling: “So gender identity is the, what gender I guess I identify as or my pronoun usage, which I choose male and I identify as male because that's how I feel.”

Interpretation of the term “Sexuality.” Participants were asked what the term “understanding of sexuality” means to them. Most of the participants had difficulty explaining what sexuality means to them and many asked for the question to be rephrased. When asked, the interviewer rephrased the question as “how would you define the term sexuality?” All participant answers to this contextual question were brief in comparison to the previous ones.

One participant captured just how complex and overwhelming the term sexuality can be when he answered, “Like, the term itself means, I jump to your gender and the acts you do and all that, but it's kind of - I feel it's more complicated. I don't really know quite yet. I'm 21. Don't know really what's going on. So, I'm learning. I'm trying to figure it out.” Other participants had simple, straight-forward answers for what sexuality meant to them, such as “Well, I guess I mean you're a guy or a girl. That's about it,” “Just anything to do with sex,” and “Who you're attracted to.”

The idea of sexuality meaning who a person is sexually attracted to seemed to be the most common interpretation. Participants often referred to the term as relating to the act of sex and who an individual chooses to have sex with. One participant expressed this sentiment with his answer:

I guess it means about where you - in terms of the concept of sex or intercourse or whatever you want to call it, it would be your preference or what you look for, I guess. I mean like, for example, if you're bi, you like both genders. So, sexuality comes down to sex, right?

Other participants expanded on this point, talking about self-expression outside of just the act of sex. One participant elaborated, “To me it means understanding, I guess - understanding what exactly I'm attracted to and what exactly brings, I guess, to light the sexual being that I can be.”

Another participant who was quite reflexive described sexuality as:

I guess that could mean a number of things, depending on the person, some people may include sexual orientation into sexuality but I don't. My sexuality is like my sexual health, I guess, and the idea that I express myself in a number of ways, not just sexually, but my open, sex-positive attitude I guess. It's all relating to sexuality.

Personal understanding of own gender identity, sexuality, and sexual health.

Participants were asked to rate their personal understanding of their own gender identity, sexuality, and sexual health on a scale of zero to ten, with zero being a poor understanding, five being moderate, and ten being a high understanding. Even though most participants admittedly struggled when interpreting the terms “gender identity” and “sexuality,” ten out of the eleven participants rated themselves as having a high understanding of their own gender identity, sexuality, and sexual health prior to the critical incident component of the interview. Two of the participants rated their personal understanding as a 10, one participant rated himself as a 9.5, two participants rated themselves as a 9, four participants rated themselves as an 8.5, one rated himself as an 8, and one participant rated himself as a 5.

After the critical incident component of the interview, participants were asked if they would change their rating of their personal understanding of their own gender identity, sexuality, and sexual health. Ten of the eleven participants chose to keep their rating the same while one participant decided to lower his rating from a 9.5 to an 8. When asked what had changed for him that caused him to lower his rating, he explained that he now realizes he still has many questions regarding gender identity and sexuality. He stated:

I guess, I was so sure of my education back then and how I'd go like, yeah, I absolutely know this and that, but I think it would be naive for me to kind of believe that I still know everything. So just constantly like learning or just being curious about how things work. Kind of made me question - my position on that scale.

After participants were asked if they would change their rating, they were also asked if they had always had a moderate or high understanding of their gender identity, sexuality, and sexual health. The participant who had rated himself with a moderate understanding, a 5 on the

scale of 0-10, explained he had always been around the same place in terms of his personal understanding, elaborating that he has never felt as though he has known much about gender identity and sexuality and that it isn't a topic that has ever concerned him or that he thought much about.

Three of the participants who rated themselves as having a high personal understanding of their own gender identity and sexuality stated that that had not always been the case. One of the participants recalled that there was a period of time in middle school where he had struggled with his sexual orientation and gender identity. He shared that he tended to have interests that were "outside of the male heteronormative," such as baking and sewing, and because of this he was often teased and called "gay" by other students in school. It wasn't until this teasing started that he began to question his sexuality and gender identity. He explained that the other students "would always make comments about it, like feminine, which is now, like, I love those things, but back then it always like, made me wonder why I like all of this stuff and I don't know why I'm different." As a follow-up question the interviewer asked what had helped him to increase his personal understanding of his own gender identity and sexuality, he answered:

Around fifteen or sixteen is when I really started to explore in the gay world. And I started meeting other men that were like myself and connecting that way. I was still very secretive and scared. And then when I was 17 I woke up and just was like screw it. This is who I am. And if anybody asks me about a girl or if I have a girlfriend or a wife I will be direct with them saying 'I do not have a girlfriend or partner or wife.' I will say who I am. But I can't say there was something specific that pushed me to that I guess. I just was sick of it. Of everything that accumulated over the years.

A second participant shared his experience of how he previously had a low understanding of his own gender identity and sexuality and why:

So, when I was 13 there was a period where I considered myself bi, so I kissed this person who was in the high school who I didn't really know, a guy, like I bragged about it a lot, but then I was like thinking over time it was like that's not really something to brag about. And I really hated it. So that was great. Then when I was 18 there was like a really long time period where I thought maybe I should be a girl. Maybe I should transition. Like I sort of regressed into men should act this way. Women should act this way. Then I had the question if I turned into a girl and am I still allowed to like girls? Like is that okay? I'd still worry about that. I have no idea. I feel like my friend pointing out like, 'hey, you behave like a girl a lot for no reason. You sort of flail your arms around when you talk and when you walk you shake your hips for no reason.' Just like really feminine. I'm like hmm, that is really feminine. Maybe there's something wrong with me, but couldn't really talk about that with anyone. And at that point my girlfriend - I'm not sure if she said jokingly or if she like holds really strong beliefs about it, we never discussed it, but she used to say 'be a man' a lot and her idea of a man was a person who owned a car, drove her around everywhere, like took care of her and that's like that's not what my idea of it was. So maybe I'm not a man.

He stated, "getting out of high school and experiencing the world and coming to college," where he began taking classes in gender studies, helped him to gain a higher understanding of his own gender identity and sexuality.

The other seven participants answered that they had always had a high understanding of their own gender identity and sexuality. One participant explained:

I've always felt like I've been drawn to - to things that are male predominant. Interested in women. Interested in, you know, more male oriented professions and interested in things like fighting, sports. More sports. Just in general just going out a lot, just enjoying myself.

4.2 Helping Categories

Five major helping categories were established through the participant interviews. A sixth category was identified but it did not reach the required 25% participation rate; it is included in Appendix G. Some participants also identified these categories as hindering or as wish list items, but they are discussed under the helping category because they were cited as being helping by the highest number of participants.

Harm Reduction. The harm reduction category contains helping and hindering critical incidents, as well as wish list items. Fifty-five percent of participants (6) described 16 helping incidents, 36% (4) of participants described five hindering incidents, and 55% of participants (6) collectively identified 10 wish list items relating to a harm reduction approach in their sex-ed class. Overall, participants indicated that learning about sexually transmitted infections and how to prevent them helped them to cultivate personal understanding of their own sexuality and sexual health. In contrast, participants found it to be hindering to learn only about the negative consequences to having sex, rather than being taught about how to prevent or reduce those negative consequences. When it came to wish list items, participants wished they had received more detailed information about STI's and how to practice safer-sex in general, the potential negative outcomes of unsafe-sex, and where and how to access condoms and contraception.

Participants discussed how they found frank and open discussions about sexually transmitted infections in the classroom to be most effective. A facts-based approach that wasn't intended to put-off the students from engaging in sexual behaviour, but rather to equip them with the knowledge and know-how to be able to practice safer-sex, seemed to be what impacted the participants most. When first asked about helpful incidents in sex-ed in general, one participant immediately responded without hesitation that "what particularly stood out to me was the emphasis on safe sex. That probably was the most useful part." Having a physical resource was found to be helpful by another participant who said "Well, there's a pamphlet they gave out on, like, the risks of unprotected sex, you know, STDs and stuff like that. So that was really - So they got that right out in the open. You know, this is what would happen if you do this."

Learning about how many types and variances of STI's that exist was also found to be helpful by participants. One participant described how he was surprised by the three main categories of STI's: viral, bacterial, and parasitic, and how many different STI's fell under each category. He found it helpful to learn "just how much health risks there were. It was an eye-opener for sure." Another participant echoed this sentiment, stating "it just really struck home."

Participants in this category spoke about appreciating that their sexual health education didn't discourage them from engaging in sexual activity or shame them about having sex, but instead gave them facts that allowed them to make their own decisions in a more informed way. One participant discussed how he had always known that condoms were one way to help prevent pregnancy, but that he had never considered using them. He explained that learning about STI's in a manner that emphasized harm reduction "woke me up to realize, don't follow your - your feelings, follow your brain. Follow the facts. Follow just - just double-check. Just use your head before you get into anything."

The theme of a harm reduction approach being helpful continued, with one participant recalling:

They didn't scare the shit out of you with pictures of people with, for example, crabs or genital warts. Instead it was conveyed in a manner that you would understand and that wouldn't totally turn you off of the idea or - or turn you off of the idea of - of, I guess, sexual education.

Another participant excitedly shared that “they actually gave out condoms in high school.” He explained that he didn’t use the condoms for sexual activity, and he didn’t think any of his friends did either, but he found being able to experiment with them on his own helped him to become familiar and more comfortable with them. This type of harm reduction approach seemed to really stick with the participants, as it was often the first helping category that was identified in the interviews. As one participant aptly put it: “it more comes down to safety concerns and about being safe, you know, protection and all that.”

Participants also discussed the hindering aspects of sexual health education that does not use a harm reduction approach. One aspect of this was that one of the participants felt he had learned only “half of the story” when it came to STI’s. He recalled learning about STI’s as if he was in a science class and not in a sexual health education class. For example, he reflected that he learned about STI’s in a more abstract way, rather than in a way that was connected to the sexual health of the students, explaining that “The AIDS and STD part I feel like wasn't really helpful. Like they just went over it for about 2, 3 classes, took up the majority of the time, just teaching us about it, rather than going over things of how to prevent it.” Another participant shared how he put himself at risk when he was sexually active as a teenager saying, “I was sexually active and exploring, like I was out with gay guys, like older gay men and stuff like

that” and how he potentially could have minimized these risks if he had learned about STI’s in a way the emphasized harm reduction:

And they did mention STIs but they never really like, so like I started to become aware of them but I had no idea, and I guarantee none of my friends still to this day have as much idea of how they are fully transmitted and everything like that. So I mean like the teacher would say ‘we have condoms if you need them’ somewhere but I don't remember ever seeing anybody get them or I never got them, but it wasn't very like, the harm reduction aspect was missing for sure.

Other participants talked about their experience of receiving a lesson on STI’s that was fear-based; focusing on sex as a risky behaviour rather than one that is healthy and normal. One participant recalled that the message he received about sex in his sex-ed class was “more just a - sex is dangerous. Like that's definitely of the general consensus versus you should be having sex, you will be having sex.” Another participant shared his experience of being shown graphic photos of individuals who had extreme cases of a sexually transmitted infection saying, “I mean I know that the pictures that they showed us, it's all of - I mean I'm talking gross people, so it's the worst of the worse cases ever possible. So I think it was instilling fear...making it seem like a death sentence.” Another participant stated, “It just scares you to think that the moment that you have sex with someone you're going to catch something.”

The lack of knowledge about how to reduce the chance of an unplanned pregnancy was brought up by another participant. He shared his experience of becoming sexually active with his high school girlfriend and how they had “a lack of understanding as to what risks are in terms of pregnancy, et cetera, et cetera, birth control, what the side effects are.” He recalled learning about STI’s and reproduction, but not about contraception. He remembered being worried about

an unplanned pregnancy, that “my girlfriend and I were really stumbling around in the dark and didn’t know what the hell to do.”

In terms of wish list items, the same themes arose for participants who wished for a harm reduction approach as those participants who found it helpful and as those who found not having it was hindering. Participants in this category wished they had learned about harm reduction when it came to sex so that they could have made more informed decisions about their sexual behaviour, to minimize risks when it came to STI’s and pregnancy, and so that they could have been better informed about contraception.

One participant spoke about how strong sexual urges can be for a young man and how he wished there would have been a discussion that would not only have normalized that, but also had offered dialogue around “precautions with like, of having it at such a young age, like wanting... like the intent, right? It's like maybe go over that. Don't just be doing it animal like that.” He wished for a sex-ed class that normalized the desire for sexual activity while also providing information on how to reduce the risks of engaging in sexual activity in young adulthood. Another participant simply wished that “STIs and that stuff should all be included and more stressed” since he felt unprepared for the risks involved with sexual activity when he was in high school.

Other participants again spoke about fear-based sexual health education and how they wished that their sex-ed had taught them about STI’s along with harm reduction strategies. For example, one participant articulated that for a lot of people, sex-ed in public school “is your first look at when you're going to have sex, this is what happens” and that this can be formative. He further explained what he wished the conversation around STI’s would look like in public school: “So it shouldn't be - shouldn't like be to be – to instill a bit of fear, but I think it should be

more be a grounds for exploring sexuality, not what can happen from sex.” Two participants wished they had learned about HIV/AIDS specifically in a way that emphasized harm reduction, with one participant wishing he knew more about the progress that has been made with HIV treatment, “especially with HIV now, that these things are...that you still live a normal life. So kind of not normalizing them in a sense, but just not making it seem so scary.”

When it came to contraception, two participants wished they had learned more about contraceptive options in general, but also wished they had learned about resources for contraception. When one participant was asked what specifically he wished he would have learned about contraception he answered “I guess learning about the accessibility of it in terms of price, et cetera, was a definite big thing. I didn't learn until like grade 12 that it was free for anyone below the age of 21.” He clarified that when he did learn about this in grade 12, it was not from a sexual health education class.

Normalization of Male Body. The Normalization of Male Body category contains both helping critical incidents and wish list items, with 55% of participants (6) detailing 14 helping incidents and 45% of participants describing 7 wish list items. In this category, the main helping theme that emerged from the interviews was the feeling of validation that resulted from learning about the male body and how it is effected by puberty.

Most of the participants shared that they had already started puberty in some shape or form before they received their first sexual health class. It was expressed that once they did learn about puberty and how it effects the male body, they felt an immense sense of relief in not only knowing that what was happening to them was normal, but that it was also OK for them to talk about it with others. One participant shared his experience of having a sex-ed class that

addressed puberty for the first time and how normalizing it was for him: “when I learned in that class it's OK to discuss - I can actually talk to my friends, ‘hey, I don't know why this is,’ and they would say – ‘I have no idea either’ and I was like great. Other people are in the exact same space as me.” It appears there was a sense of comfort in knowing he wasn't navigating this confusing time alone. For another participant, sex-ed in public school was the first and only time he had the opportunity to learn about his changing body in any context:

I guess it was just really helpful in a sense that we're allowed to learn about our bodies and that it was kind of validating that it wasn't weird to talk about it, because even if it was weird at the time, I guess looking back it was nice to have that, 'cause I know my parents wouldn't have spoken about that with me or any other person really.

Puberty in general was a topic that most participants found to be helpful in their sexual health education class, with different participants identifying different parts of puberty that were most memorable to them at that time. While some participants took away a general theme from their sex-ed class, for example, “puberty means that you're going to see change in the body. Don't get freaked out,” others recalled specific changes, that when addressed, brought them comfort. Examples include “it was nice to know about the different places hair grows,” and “our voice would start cracking and it would always be funny, we wondered why.” One participant recalled being bullied for being smaller than the other boys in his class, and that for him to learn “the fact that some people may start puberty earlier than others and that they aren't more or less of, for example, a guy because of that” reassured him that he was normal.

Anatomy of the male reproductive organs and how they function was a major helping factor that emerged under the Normalization of Male Body category; “the anatomy part was, I mean it helped you understand your own body.” One participant identified seeing cross-sectional

diagrams of the male genitals as being particularly helpful, saying, “I guess it was validating on a very like, anatomical sense, like how my body is allowed to do that or oh, it isn't weird that I do that.” When talking with participants about puberty and male genitalia, learning about erections came up most often as being helpful. For example, when asked to go into more detail about what was most helpful when learning about puberty and the male body, one participant stated, “I think just learning about - like on a very specific sense, learning about erections, because it was just kind of like this new thing to me at the time”. When asked why learning about erections was particularly validating, one participant answered, “the comfort of what was happening, if I got an erection or something, something like that is normal, that they can just happen at any time.”

Learning about erections was wished for by nearly half of the participants in this category. All the participants who wished for more conversation about erections shared the same sentiment, that learning about how to cope with spontaneous erections and the embarrassment that came with them would have been helpful. For example, one participant voiced the frustration he felt as a teenager recalling how he would lament, “trying to figure out ‘why is it getting bigger’, you know. And, like, yes it gets taught that, you know, it's normal for that to happen, but, you know, what do we do about it?” Another participant explained that he wished that there had been a broader conversation that normalized erections to all students, regardless of gender, that relayed the fact that erections are very difficult, if not impossible, for young men to control:

you know going through high school and you go - walking in the hall and you see a cute girl or whatever and it happens and you're just like "Oh, this is awkward. Now everyone can see this" sort of thing. I feel like if that was taught in a way that people can embrace that, that happens and not get mocked for it, that would be good.

Condom Demo. The Condom Demo category contains only helping critical incidents, with 45% of participants (5) detailing five helping incidents. Participants explained that watching a live demonstration of how to effectively put on a condom was very helpful in cultivating understanding of their sexual health and their sexual practices. For example, several participants recalled how seeing a live condom demo was helpful to them when they engaged in sexual intercourse for the first time. One participant explained: “Well, my first time would have been exceedingly more awkward, which it was still awkward, but I could put it on and she was like, there wasn't like a hiccup in the action. So, like, yes. Good job banana.”

Referring to the condom demonstration he had received in his sex-ed class, one participant stated, “How to put on a condom. I had no idea. That was great.” Another participant recalled in detail his experience of watching a condom demo. He explained how the instructor had used a wooden dildo that was referred to as “Woody” and went over the ten steps of properly putting on a condom. This participant stated, “it was probably the most perfect method for delivering that kind of information.” Participants who identified a condom demonstration as being helpful were asked what specifically about the demo was so helpful; some participant answers included: “Seeing it made it - reinforced it,” and “How important it is to know how to use protection, so for males, condoms, and for me I just open the package and just put it on. But he went in-depth. He said you have to do this.” For these participants, having a detailed, step-by-step demonstration of how to properly use a condom seemed to not only teach, but reinforce, how to properly use a condom.

Anatomy and Function of Female Body. The Anatomy and Function of Female Body category contains both helping and hindering critical incidents. However, only 9% of participants

(1) reported one hindering incident, failing to meet the required participation rate of 25%. It is detailed in Appendix G rather than being discussed in this chapter.

Thirty six percent of participants (4) identified four helping incidents with two central themes emerging in this category. The first theme was learning about female anatomy in relation to sexual activity as being a helpful factor. One participant expressed how he had a general idea of what female anatomy looked like, but that before his sexual health education in public school, he did not know any specifics. He recalled being unsure of the mechanics of sexual intercourse and that learning about the locations of the clitoris, urethra and vagina was very helpful to him. He stated, “Because at that point I was wondering where girls pee' d from. That was - that was great.” The other participant felt less comfortable elaborating on what exactly was helpful about learning about female anatomy, but he offered, “Because it just helped you fill, helped you with understanding of, like, you know sex.”

The second theme that emerged in this category was how learning about menstruation was a helpful factor. Two participants identified learning about the female reproductive organs and the menstrual cycle as being helpful to them in their understanding of the female body. One participant explained that he has older sisters who he had often overheard talking about their “periods” and that learning about menstruation in his sex-ed class helped to de-mystify the topic. Another participant recalled how learning about the female body and the menstrual was helpful:

They went over the female anatomy and then we went over like menstruation, the menstrual cycle and stuff, and then a couple years later a good girlfriend of mine, she got her period. And then it was like a big dramatic thing and I remember telling her some stuff that I learned in grade 6 too, like it's a normal thing and trying to help her be comfortable I guess.

Anonymous Question Box. The Anonymous Question Box category contains both helping critical incidents and wish list items, however, the wish list items for this category fall under the 25% participation rate. They are not included in this discussion of the category and instead can be found in Appendix G.

Twenty seven percent of participants (3) identified six helping incidents in this category. An anonymous question box is a box in the classroom where students can write a question on a piece of paper, without any identifying information, and later in the class the teacher reads out each question and answers it to the class. Participants explained that this was helpful because “no one would know who asked that question. So you wouldn't be embarrassed about it,” and “I know that we definitely wouldn't be asking these personal questions” if they had had to ask the questions out loud in front of their classmates.

Participants also spoke about the normalizing and validating effects the question box provided for them. For example, one participant explained:

The box actually really helped. Like that kind of anonymous, like everyone had to submit something so it wasn't empty. So, yeah. That was really helpful, because I don't really remember what questions were asked, but I remember thinking ‘oh, yeah’, like I guess I thought of that too.

Knowing that other students were wondering about the same things as they were helped them feel as though they were “normal”. Another participant shared that the anonymous question box also provided an opportunity for personal growth and exploration in addition to normalization and validation, stating:

I think it was knowing that my peers also had questions similar to mine and that, you know, even if we were all laughing and kind of not taking it as seriously as we should have, it was still really nice that there were people who were really interested and really actually wanted to know more about themselves.

4.3 Hindering Categories

Five hindering categories were established from the participant interviews, however, three of the categories failed to meet the 25% participation rate so are not discussed here. They are detailed in Appendix G. The following two categories have helping, hindering, and wish list aspects to them, but they are discussed under the hindering category because they were cited as being hindering by the highest number of participants.

Instructor and Delivery. The Instructor and Delivery category contains helping and hindering aspects, as well as wish list items. Most of the participants in this study identified hindering aspects related to instructors and/or the way the sex-ed material was delivered to the class. Ninety one percent of participants (10) detailed 19 incidents that they reported as hindering to their cultivation of their personal understanding of their own gender identity, sexuality, and sexual health. Conversely, 55% of participants (6) identified 25 helping incidents related to their sex-ed instructors and method of delivery. In terms of wish list items, 64% of participants (7) identified 8 wish list items.

Overall, there was a theme of participants sensing the general discomfort of the instructor who provided their sexual health education, and this was viewed as a hindering factor. Participants in this category spoke about how sexual health is generally an uncomfortable topic for students, and so having a teacher who perpetuated the idea that sex and sexuality should not

be talked about openly, made it more difficult for the students to be engaged in the class. One participant explained that “Not feeling the comfort of the teacher...it continued the cycle of sexuality and sexual health being taboo.” Another participant, when asked about hindering aspects of his sexual health education, stated “The comfort of the teacher. Like the teacher’s uncomfortable, we are uncomfortable, just like a mess.”

Participants in this category discussed how they felt as though they couldn’t, or shouldn’t, ask questions or initiate a conversation with their instructor on the topic of sexual health, even though it was a sexual health education class. For example, one participant simply said that because of the awkward vibe in the classroom that emanated from the instructor, “I didn’t want to ask any questions or anything.” Referring to his sexual health instructor, another participant remembered thinking “I’m not comfortable discussing anything with him. Like not even what I had for lunch yesterday,” let alone anything to do with sex or sexuality. Finally, one participant expressed how, because of the instructor’s discomfort, his sexual health education class left him feeling more confused than before the class: “I was left in more suspense and uncertainty and I didn’t really want to go back to that librarian and ask her again, because the way she kind of said it kind of made me feel more distant to talk to her.”

More specific than general discomfort, participants spoke about how the lack of engagement they noticed from their instructors as being a hindering factor. Participants in this category expressed that when their instructors did not seem interested or did not display effort in delivering the content, it was harder for them to engage as well. Different participants had different experiences of what this lack of engagement looked like. Some examples include an instructor who was unprepared to answer questions from the students: “I felt like he was getting really frustrated from being asked questions. I remember one class he actually just left,” and an

instructor who seemed bored by the content herself: “She didn't make it exciting. She might have made it a little bit more awkward because of that, continuing in her own kind of verbal monotone.” Another participant expressed feeling “no connection” to the instructor because of the instructor’s uninspiring traditional lecture style that. He recalled thinking, “Why did we have to be taken out of our normal class to listen to this old lady speak?”

Aside from the instructors themselves, the methods that the instructors used to deliver the sexual health content was also seen as a hindering factor by some participants. For example, when asked why the style of teaching used by the instructor was unhelpful, one participant answered, “Just dry material. The professor - or the teacher in elementary school was pretty old fashioned.” Other participants shared the view that a simple lecture style was not helpful in getting them engaged in the class. Another participant explained that his instructor simply used outdated videos to deliver the sexual health content, “it was just like the PE teachers putting on a video,” and that this made it hard for the student to take the class seriously.

Other participants, however, described incidents where their sexual health instructor made it easier for them to be engaged in the class and cultivate understanding of their own gender identity, sexuality, and sexual health. Fifty five percent of participants (6) detailed 25 helping incidents in this category. Most of the incidents reported had to do with the energy level of the instructor and how they seemed passionate about the topic of sexual health. A lot of participants shared that they felt more comfortable becoming active in the class in terms of focus and attention when the instructor was, in general, an engaging person. Some examples of terms used by participants to describe instructors who they felt comfortable with included “warm,” “passionate,” “knowledgeable,” “youthful,” and “relatable.” One participant recalled how his sex-ed instructor, who was an external educator brought in by the school, was energetic and how

he was able to motivate the students: “He'd get excited. He'd be jumping. Literally he'd be jumping. And everything would shake. It was just so engaging. So much energy.”

Like the hindering aspects of this category, the way content was delivered by the instructors was also cited as being helpful by some participants. It seemed that the more variance there was in how content was delivered, the more helpful participants found the class. When asked what it was about the instructor’s teaching style that was so helpful, one participant answered, “Just the method of how he presented all the information. Good balance between slideshows, oral presentations and demos.” Another participant described how a team of two instructors were brought into the school to teach sexual health content. He recalled how they used a variety of methods to deliver the content, including role playing acting out skits. The participant explained that the way the instructors were proactive in getting the students involved in the scenarios was particularly helpful for him: “with the skit, they got people involved because they said, you know, "What's wrong with this scenario? What would be a better option for this guy to say or do?" So it wasn't just watching it fully. That's what I mean by, like, getting involved.”

Sixty four percent of participants (7) identified eight wish list items in the Instructor and Delivery category. One simple wish list item from one participant was to have someone in the school who was designated as the person who can answer questions about sexual health. This participant wished for consistency for the duration of time he spent in that particular school. He explained, “really, I guess, what set a light to my desire to learn more or to have a bit more sexual education is when, like, I had no one to talk to when I had questions. So, being able to have someone who is appointed to - or who has a clear role as a sexual educator would definitely be beneficial.”

As in the helping and hindering aspects of this category, an engaging instructor was wished for by most participants who identified wish list items. “Being more engaging would probably be the biggest thing of all.” Specific characteristics of what would be most helpful in an instructor varied amongst participants. One participant wished for an external instructor: “Bring in someone from the outside so it's more engaging. Some unfamiliar face. Just the fact that you don't know the person, as a kid you're drawn to them because like oh, you're new. I've never seen you before,” while another preferred “a familiar face” who was known within the school. Another example of an ideal instructor that a participant wished for was someone who is “like younger but, you know, still an expert. It might be someone fun and, you know, just like, you know, passionate about health and like education and stuff like that and also, you know, good with kids.” Overall, the consensus among participants who wished for a more engaging instructor was expressed succinctly by one participant who stated an ideal instructor would be “someone who can really connect with or like that makes you comfortable.”

Some participants also wished for the content delivery of their sex-ed classes to have been more varied and engaging. Having the class delivered in one format only was expressed as undesirable by two participants, who instead wished for “just a speaker instead of like a Power Point” and “The teacher actually talking, because not wanting to listen to something that's prerecorded, doesn't really engage, it's not asking you questions.”

Peer Influence and Behaviour. The Peer Influence and Behaviour category contains hindering aspects only, with 73% of participants (8) describing 10 hindering incidents. Participants found that peers who did not pay attention in class or made light of the class by joking and laughing, hindered their ability to learn or that it influenced them to adopt the same

behaviours. Additionally, participants described fearing ridicule from peers when in a group setting that was focused on such a sensitive topic.

When asked what about his sex-ed class was hindering in cultivating understanding of his own gender identity, sexuality, and sexual health, one participant aptly responded, “there wasn't enough care in the students for it to really be useful.” A second participant also reported feeling as though his peers were uninterested in learning about sexual health and how this was hindering to him. He stated, “I think it was grade nine where it got to a point where some kids would just be skipping the class and not showing up. And to me it was like, and I know that happens in a lot of classes, but it breeds the mentality of that nobody cares.” Two other participants described how in the classes peers were actively disengaged, giving the example: “All the students ended up just going on their phones, playing underneath the desk with their phone, right? No one really wanted to pay attention.” The other participant explained how not only was it hindering that other students weren't paying attention, but that it influenced him to also disengage from the lesson: “Probably just 'cause it was grade 10 and you just sort of follow the crowd, since everyone else wasn't paying attention on their phones, so I just followed the crowd as well with my phone.”

Participants in this category also described their sexual health classes as not being taken seriously by peers and instead the lesson was turned into a laughing matter: “It was like, half of it was a joke. You know, it's like oh, we're laughing about it. Oh, it's no big deal. Doesn't matter.” The immaturity of peers was an often-cited hindering factor. One participant explained, “You're dealing with kids who laugh at the word penis. So there wasn't a sense of seriousness even taken towards it half the time. You know, half the time it was kids laughing about stuff or seeing a banana or whatever and take a condom off or whatever.” Another participant recalled a specific

instance when peers were “like giggling and laughing” as a video that showed a father talking to his son about erections was being played. The participant stated “Like, they weren't taking it seriously or anything.” Another participant described how the behaviour of his peers hindered the cultivation of his personal understanding of his own sexuality in a serious way, explaining,

Kids would like make jokes or homophobic jokes that would then like make me just internalize who I am and where I was and I was just like, I'm just going to try and be normal, so-called normal, and just like go with the flow with everybody here instead of trying to find out who I am and be myself and stand out.

Finally, participants expressed that they were hindered by their fear of being ridiculed by peers if they asked their questions out loud in their sex-ed class. When asked what it was he meant when he listed peer influence as a hindering aspect, one participant answered: “It means that if you have any questions you're afraid to ask. I recall that there was a question box, but I think that I may have had questions, but I didn't put a question in the question box because people would be like, okay, what question did you put in the question box?” Another participant elaborated that he felt for males especially, peer influence was hindering, stating, “They just asked, you know, a group of young boys, like ‘Do you ‘have any questions?’ And everyone was ‘No’, but I'm sure every single one of those people had at least one question.” Participants in this category felt as though they were unable to talk about sexuality and sexual health in front of their peers, and were left to their own devices to navigate their sexual health. For example, one participant explained, “it was kind of like because, like, your friends were there you probably didn't want to talk about it. So it was kind of like, oh, I guess I'll figure it out on my own or - or I can Google the internet, even if it isn't right.”

4.4 Wish List Categories

Nine wish list categories were established through participant interviews, however, three of the categories failed to meet the 25% participation rate so they are not discussed here. They are detailed in Appendix G. The following six categories have helping, hindering, and wish list aspects to them, but they are discussed under the wish list category because they were cited as being wish list items by the highest number of participants.

Gender Identity. The Gender Identity category had the second highest participation rate out of all the established helping, hindering, and wish list categories, with 82% of participants (9) describing 10 wish list items. The central theme that was pulled out of the wish list items in this category was one of language; most participants wished they had been educated about the language and the politically correct terms that are used when discussing gender identity. Participants also wished for education around gender identity so that they could understand others, and themselves, on a deeper level. One participant captured the general sentiment expressed by participants in this category, which is that they feel ill prepared to understand gender identity as it emerges as a much more mainstream issue, when he stated: “I think a lot of it comes down to, nowadays, is a lot - sex and all that has branched off into many other things, like with gender identity and stuff, like, too, I feel like that is something that really should be taught.”

It was this line of reasoning that led some participants to include learning about gender identity and language on their wish lists of what they would want from a sex-ed class. For example, one participant wished to learn “I think even on the very introductory level, like pronouns and just how people of other genders kind of deal with the world and how they identify.” Another participant wished to learn about “all the different types of sexual identities.

Like cis, transgender, all the stuff like that. I feel like that would be something that would be really useful.” When asked why learning about gender identity would be beneficial, one participant answered, “Because I know that a lot of people might have had those questions and they know not to talk about it because it might come off offensive or even just kind of inappropriate.” This statement shows recognition of the unintentional hurt that misusing language can inflict on another person.

Several participants described situations in which they had used incorrect pronouns when referring to an individual or when they used a politically incorrect term, such as “tranny,” and thus received backlash from the people with whom they were engaged in conversation. Participants were emphatic that they had not intended any malice when in these situations, but explained that they simply did not know the correct terminology. One participant stated:

It's just tough because the way I was raised is that when I saw somebody who was male I would identify them as he. A female was she. That's how I was raised. Nowadays it's a lot harder to just say that. So to me it's about myself learning at what points I need to choose my language carefully.

Participants spoke about feeling overwhelmed by all the labels people use to identify their gender and expressed that they wished for education around gender identity so that they could be sensitive to others. When asked about why he wished for education around correct terminology, one participant discussed how he felt bad that his lack of awareness could negatively impact others, saying, “Like I don't know terms, cis or trans, people like that, that's not fair to those people who identify as that.”

Aside from being equipped with just politically correct terminology and language around gender identity, participants spoke about other aspects that they believed would be beneficial if

they had received education around gender identity at an earlier age. One participant explained why he wishes sex-ed classes would address this topic in public schools:

I think that going forward it would be important to sort of educate, I guess students, about the fact that there is, I guess, on a spectrum of gender identity and that it is important to understand where you are for the sake of mental health and for the sake of -- I guess learning who you are in your formative years.

When asked why they wished for education around gender identity other participants talked about how it could foster acceptance and inclusivity at an early age. For example, one participant stated, "I'd hope that perhaps it would be like less of a negative, like a stigma to that, in people who are - are somewhat confused about who they are or identify themselves differently."

Another participant explained, "Like all the transgender people, we didn't learn anything about that. It would have been nice to know. I feel like people would have been probably accepted more."

Finally, one participant talked about gender identity in terms of socially prescribed gender roles. He explained why he wished he had received education around societal expectations of what it means to be a man or a woman and how that would have helped him to cultivate personal understanding of his own gender identity:

I think it would have helped me understand other people, but also myself, and kind of - it would kind of released me from toxic messages and just kind of like how we were expected to act and that sort of thing. I guess - I guess tough. Not crying. Or even the - the perception that guys are more sexual and that girls are more submissive. And that sort of dialogue.

That such a high number of participants wished for education around gender identity did come as a surprise, but one participant summed up the importance of learning about gender at a young age perfectly when he said, “it's becoming so much more broad and apparent now that there needs to be some sort of change and improvement with really being inclusive, we need everyone together on this so that people can really understand it.”

LGBTQ Inclusive. The LGBTQ Inclusive category contains both wish list items and hindering aspects, with 55% of participants (6) detailing 8 wish list items and 45% of participants (5) describing 11 hindering incidents. Participants expressed a desire for an inclusive curriculum that addressed variance in sexual orientations and sexual behaviours. Conversely, it wasn't LGBTQ inclusive content that was described as hindering, rather, it was the heteronormative and cisgender perspective that was used in the sexual health education they received that participants reported as hindering.

Reasons why participants wished for more LGBTQ inclusive content varied. One participant simply believed that everyone has a right to learn about sex and while some individuals may not feel comfortable talking about non-heteronormative sexuality, that is not a reason to exclude LGBTQ content from sexual health education. He explained, “Everyone deals with their sexual tendencies and urges or whatever in a different way. Some, yes, are more awkward than others and it's a little uncomfortable for some people, but at the end of the day it's, you know, we have to talk about it.” Another participant reflected how at one point in his adolescence he was questioning his sexuality, and he now wishes his sex-ed class had been able to normalize the confusion he felt about his sexual identity as well as addressing sexual

orientations other than heterosexual. He recalled wondering, "Is it okay that I'm like -- you know, for a guy to like a guy? Is it okay that I don't - I don't identify myself as anything?"

Normalization was the main theme that emerged from LGBTQ inclusivity being a wish list item. Many participants in this category expressed that they wished they had learned more about non-hetero sexual activities from a harm reduction perspective. When asked what specifically about LGBTQ inclusive content he wished for, one participant answered:

I guess I would say sexual practices, other than just hetero related. So we're at the - yeah. MSM [men who have sex with men], for females exploring other options, and you don't have to blatantly ask who is having sex with who, but just discussing this is what this looks like. This is what you - this is what your risks are, this is what what your practices will be. This is how you have safe practices and just exploring sex with our genders.

Another participant expressed a similar sentiment, describing how having an educator who was comfortable and experienced with same-sex education would have been normalizing:

The same-sex education piece or having like an actual experienced person come in would have made a big difference, speaking about same-sex and actually like, speaking about same-sex, not just like 'oh you know it could be a man and a woman, a male or female,' but actually talking about same-sex education and intercourse and the risk factors and the positive and negative, everything. I think that would have made a huge difference.

After identifying LGBTQ inclusive content as a wish list item, one participant was asked what he thought might have been different if he had received more inclusive sex-ed. He answered:

I definitely would have felt more accepted and open. I think it would have actually created more dialogue even between me and friends if they had stressed that fact that, not

stressed it, but openly talked about it and comfortably talked about same sex, maybe that would have created an opening for me to feel more comfortable personally and with my friends. Like " hey remember they talked about that in class?"

Five participants in this category described their sexual health education as being heteronormative and as being delivered from a cisgender perspective. They expressed that they found this to be hindering to the cultivation of their personal understanding of their own sexual identity and sexuality. One participant explained why this cultivation didn't seem possible for him, saying, "I think it was just because it was so hetero based that you - it's almost like it didn't give you a practical thing for yourself in terms of this is the way that I'm - like that I see myself." Another participant expressed how, because he identified as gay, he felt excluded and "othered" in his sex-ed class: "it wasn't talked about, that was, wasn't something that was talked about anywhere really. Like same sex or homosexuality wasn't really talked about at all." Finally, another participant recalled wondering "what about other identities?" while he was in his sex-ed class.

In terms of safer-sex practices, some participants discussed how the lack of same-sex education not only excluded their sexual preferences, but even put them at increased risk in terms of STI's. Reflecting on their sexual health education, participants who identified the lack of same-sex education as hindering, spoke about how their specific needs weren't addressed. For example, one participant stated, "I don't recall much conversation about anal sex and increased risk that way," and another participant couldn't recall any same-sex behaviours being included in the lesson either, saying, "I feel it was mostly strictly vaginal." Finally, one participant articulated why not having same-sex education, especially from a harm reduction approach, was hindering to his sexual health:

There was no same sex education in the slightest in any of those classes which I think put me at a huge risk because yes, I knew what HIV was and yes, I knew what an STI was, but on a very small scale. I had no idea the risk I was putting myself at when I started getting sexually active at 15 with older men. I had no idea. And I truly believe that not having any same sex education I put myself at risk and I, and I'm very, very lucky that I didn't get anything, but a number of kids do. Especially HIV rates in kids under 16 are increasing every year, so it's like, we clearly need to find a better system.

Class Size. In the Class Size category, there are both wish list items and hindering aspects, with Forty-five percent of participants (5) identifying 5 wish list items and thirty six percent of participants (4) described four hindering incidents.

Participants in this category agreed that a smaller class size was wished for when it came to sexual health education. Participants had varying ideas of what exactly would be the best class size, with some participants wishing “for a time with the counselor for a one-on-one sex-ed thing,” and others describing a small group of only a few students as being ideal: “small groups of people, that would have been beneficial.” The main reason why a small class size was a wish list item was for confidentiality reasons. One participant explained that for him, a small class size “would have been a little more of a learning experience. Or a question period, to like actually have that confidentiality.” Another participant, referring to larger classes, stated: “you know, like obviously no one wanted to ask questions; right?”

Some participant in this category spoke about how they found a large class size to be hindering to the cultivation of their personal understanding of their own gender identity, sexuality, and sexual health. One participant explained that for him, a large class size provided

an environment where it was easy to lose focus, stating “It was basically asking to get distracted. Asking to not pay attention.” Other participants reflected that a large class size took away any chance of fostering a sense of safety where students could share or ask questions. For example, one participant explained that his sex-ed class was a large group, and that he believed the students “didn't want to share anything, or if they did, anything personal, which they didn't. I don't feel like that's a platform where someone would be willing to share.”

Continuous Education. The Continuous Education category contains helping and hindering aspects, as well as wish list items. Nine percent of participants (1) described having had continuous sexual health education throughout public school and identified this as a helpful factor, but this failed to reach the 25% participation rate so is not included in this discussion. It is detailed in Appendix G.

Thirty six percent of participants (4) identified eight wish list items in the category of Continuous Education. Participants in this category wished that they had received sexual health education on an ongoing basis throughout their time in public school so that there was an opportunity “to build off the stuff you learned before,” and “because if there's no follow-up, I mean then you have no feedback and no communication as to what's being learned and what's not being learned.”

Some participants expressed that they wished their sexual health education had started in elementary school. One participant stated, “I wish there was a bit more, like, in my earlier years.” Another participant, after reflecting on the one sex-ed class he had received, discussed how continuous sex-ed that started early on in public school could have normalized sexuality and sexual health for him, and how he wishes for that opportunity for future students:

Now looking back I think that it should be more than just a class, it should be longer and a consistent thing to break that taboo. I think that would benefit. I don't know how they would completely incorporate it but I think the BC school system needs to restructure its sexual education completely and include it more frequently and even younger now, because kids are going through puberty at eight nine ten years old. Grade 6 is too late.

One participant wished he had had continuous education because he felt like he didn't get the sexual health information he needed when he needed it. Referring to sexual health and sexuality he stated, "And I didn't get taught anything like that in grade 11 or 12, you know, when - when it was a lot more apparent that stuff like that was happening right around me, you know. That would have been a lot more beneficial and a lot more useful." Another participant discussed how he had felt overwhelmed by the one sexual health education class he received in middle school, reflecting that "they could have probably just broke it down, reducing a lot of information, but made the information clearer and broken apart instead of just one year; broken into grade 6, 7, 8."

Thirty six percent of participants (4) described four hindering incidents that resulted from not having had continuous sexual health education and instead having brief, intermittent, or absent sex-ed. One participant described receiving brief and intermittent sex-ed as "cement kind of being poured with no real foundation. So being spilled along freely and it didn't really have any borders to stop it." He felt as though the information was given to him, but that he was not able to organize it or understand it in a meaningful way.

Other participants spoke about how having one-off classes of sexual health education was hindering to their ability to cultivate understanding of their own gender identity, sexuality, and

sexual health. For example, one participant reflected on the one sex-ed class he had received, saying, “it gave a constrained amount of time to be able to speak or for the whole thing to run. Like one block certainly didn't help because if anyone had questions and they wanted to wait longer before asking, you had no time.” Another participant explained that his one sex-ed class “kind of hindered my understanding, because I think that it should be - knowing that kind of thing doesn't just happen like in one week or even in one school year. There's always going to be questions people have about how their body works, like over - over the course of their life.” Finally, one participant simply stated that his brief sexual health education “just left me with more questions and in a more uncomfortable position than before.”

Sex Positivity and Normalization. The Sex Positivity and Normalization category contains only wish list items, with 36% of participants (4) detailing four wish list items. Participants in this category expressed that if they had had sexual health education that discussed sex and sexuality in a sex positive and normalizing way, they believed they would have been better able to cultivate their personal understanding of their own sexuality and sexual health. One participant explained that “If at 13 we discussed the sexuality, how it's not, you know, a bad thing, I don't know how actually they - if they would say it's not a bad thing, but if that was the topic, if that was what everyone took out of it, that would be really good.” Two other participants expressed that they wished they had received sex positive education because “I think it would have helped for us to realize that sex is a really important part in our lives,” and “to know that exploring your body is healthy.”

In terms of normalization, participants spoke about how they wished for validation that what they were going through in terms of hormone changes and sexual urges was healthy and

normal. Masturbation and “how to cope with being horny” were two specific topics that were identified by some participants as having caused them confusion and shame. It was wished for by these participants that they had received sexual health education that not only normalized these issues, but offered advice on how to cope with them in a healthy way. For example, one participant wished he had learned:

...how to deal with that sort of stuff. Like even talking about masturbation. You know, about like, even - not like a how to, but like just some sort of explanation about what it is and, you know, what it means when it happens.

Another participant agreed, saying, “I feel like there needs to be a lot more emphasis on just - on how kids deal with their horniness or whatever.” As one participant expressed, he just wished that his sexual health education would have been able to convey the message that “just over all, just making it clear that everyone, that - you're not weird.”

Consent. The Consent category contains only wish list items, with 27% of participants (3) identifying three wish list items. Participants in this category wished they had received sexual health education around the topic of consent because it is such a complicated topic and that “some people don’t get it”. The complexity of consent was expressed by one participant when he explained that he believes sexual health education around consent could be “helpful in the sense of like discussing rape culture or what it means to give consent or even how abuse shapes our sexual understanding.”

Another participant reflected on what he wished for and what he would have advocated for if he was back in high school:

I feel like I should have wished for it because like obviously consent is what it is. I think most people understand that. Like a huge majority. But there may be somebody that doesn't, and even if it's repetitive for someone else, the fact that it's out of place, that they don't know about that, it would have been really good for them. So I hate the idea that oh, you should teach males not to rape. Because everyone knows, everyone's been taught that just growing up as a decent human being, so not specifically that, but hey, if your partner says 'yes' or 'no' that's how you should react and if you're like angry about it, if you are upset about it, maybe schedule a counseling session. We can discuss ways to cope with that. Oh, that would be great.

CHAPTER FIVE: DISCUSSION

The purpose of this study was to learn from young adult males' what critical incidents of sexual health education (SHE) helped, hindered, and were wished for regarding the cultivation of understanding of their own gender identity, sexuality, and sexual health. In this chapter, the findings of the study are examined as to how they compare with the previous literature, followed by discussion of the study's unique contributions. Implications for practice in the fields of education and counselling psychology and for future research are then reviewed, and finally, possible limitations of the study are considered.

5.1 Situating the Findings Within Previous Research

Contextual Findings. The contextual findings of this study fit within the existing literature regarding the "definition" of sexual health education, gender identity, and sexuality. It is important to note that when the word "definition" is used, it is meant as a working definition or interpretation, and not a concrete, inflexible term. As suggested by the Public Health Agency of Canada (PHOC), professionals should avoid defining terms such as "sexual health education," "gender identity," and "sexuality" "because our understanding of sexuality is socially constructed and as a result, a non-ideological or normative definition is impossible" (p. 12).

Interpretation of Sexual Health Education. The contextual findings show that the interpretations of the term sexual health education by the participants are supported by the working definitions of sexual health education and health education that are discussed in the literature.

Nine out of eleven participants interpreted sexual health education as meaning sex-positive education. They described it as a form of knowledge sharing that should promote an

open, accepting, and inclusive attitude towards sex and sexuality, while learning about sexual health in an informed and factual way. They spoke about being equipped with the knowledge to make informed and healthy decisions in a way that frames sex as being normal and healthy. Although there is no strict definition of sexual health education, most experts agree that effective sexual health education is respectful and sensitive to the diversity of individuals, while providing the necessary information to help individuals attain the knowledge and skills to make healthy sexual decisions (Public Health Agency of Canada, 2008; World Health Organization, 2008).

Seven participants also included learning about the possible risks associated with sexual activity and how to prevent them, more specifically, sexually transmitted infections and unplanned pregnancy, in their interpretations. Participants discussed sexual health education as meaning an opportunity for adolescents and young adults to learn about anatomy, reproduction, STI's, and pregnancy with a focus on how to avoid any potential negative or unwanted consequences. This is corroborated by the PHOC's (2008) definition that includes preparing individuals with the behavioral skills and factual information that can not only prevent negative sexual health outcomes, but also help to increase positive outcomes of safe and pleasurable sexual experiences.

Gaining understanding of oneself and of others was also identified by four participants in their interpretation of sexual health education. This idea was described as an opportunity to learn about other lifestyles, relationships, orientations, and gender as well as to gain confidence to navigate becoming a sexual being who shares sexual experiences with others. Being able to critically think about one's own sexual health and sexual identity, how it is influenced, and how it impacts the way one connects and relates to others was interpreted as being an important part of sexual health education. In their definition, the PHOC (2008) includes the statement:

“Effective sexual health education maintains an open and nondiscriminatory dialogue that irrespective of their age, race, ethnicity, gender identity, sexual orientation, socioeconomic background, physical/cognitive abilities and religious background” (p. 4). It is also noted that self-esteem and respect for self and others is a goal of sexual health education (PHOC, 2008).

In summary, sex-positivity, a harm reduction approach that emphasizes how to have safer-sex, and the ability to cultivate personal understanding and understanding of others were core components of the participants’ interpretation of sexual health education. These concepts are in line with the working definitions of sexual health education set by the World Health Organization (2008) and the Public Health Agency of Canada (2008).

Interpretation of Gender Identity. Although participants expressed that interpreting gender identity was difficult for them, and that they felt unsure of their answers, the contextual findings show that most participants did interpret it in a way that is supported by the working definitions that are found in the literature.

Eight of the eleven participants discussed gender identity as meaning how one understands or identifies oneself. This is a key aspect of gender identity, as it is an individual’s internal sense of feeling of what their gender is that influences how one identifies their gender (Human Rights Campaign, 2017; PHOC, 2008). Six participants identified that gender identity doesn’t always match the biological sex that was assigned at birth and that it can be non-binary, describing gender as being on a spectrum. This is in line with the both the Human Rights Campaign’s (HRC) (2017) and the PHOC’s (2008) working definitions of gender identity.

Finally, three participants included the use of language, specifically pronouns, when interpreting the term gender identity. They spoke about how an individual chooses the pronouns that they feel are best suited to them, and the importance of addressing a person by their chosen

pronouns. This is embedded in the HRC's definition of gender identity also: ". . . how individuals perceive themselves and what they call themselves" (HRC, para. 2).

Two participants interpreted the term gender identity as meaning sexual orientation, or who a person is attracted to. This is not in line with the current working definitions of gender identity in the existing literature, and is instead more in line with the term sexual orientation, defined by PHOC (2008) as "A person's affection and sexual attraction to other persons, regardless of gender" (p. 51).

Interpretation of Sexuality. Participants expressed that they had a difficult time interpreting the term sexuality, as they should have. Sexuality is a broad and complex term that can encompass many meanings. However, in their interpretations, all the participants touched upon some aspect of sexuality that is included in the WHO's (2008) working definition of sexuality.

One participant succinctly interpreted sexuality as meaning "anything that an individual is related to in terms of sex." Eight of the eleven participants spoke about sexuality as being a means of expression; how one expresses themselves in terms of sexual behaviours, their attitude towards sex, ways of dress, and sexual health practices. Three participants included sexual orientation, or who a person is attracted to – whether platonic or romantic, in their interpretation. Finally, one participant defined sexuality as "whether you identify yourself as male or female." All of these interpretations fit into the WHO's (2008) definition of sexuality:

. . . a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these

dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors. (WHO, 2008, para. 5)

Critical Incident Findings. This section will begin by situating the critical incident categories that met the minimum 25% participation rate within existing literature. Certain categories have been grouped together for discussion to reduce redundancy. The groups of categories are: Harm Reduction and Condom Demo; Normalization of Male Body, Anatomy and Function of Female Body, Sex Positivity and Normalization, and Consent; Anonymous Question Box, Class Size, and Peer Influence; and Instructor and Delivery.

Harm Reduction and Condom Demo. The findings in the Harm Reduction and Condom Demo categories can be fully supported by the literature. Published research corroborates the participants' identification of a harm reduction approach in sexual health education as being a helpful factor. Studies surveying adolescents, including male-only groups, show that participants described sex-ed that emphasized measures that can be taken to prevent negative outcomes of sexual activity as effective and meaningful (Armstrong, 2003; Byers et al., 2013; Cupples et al., 2010; McKay & Holowaty, 1997; Sherrow et al., 2003). Participants expressed that SHE with a harm reduction approach was perceived to be of high quality and had a positive impact on their development and behavior (Byers et al., 2013; Cupples et al., 2010).

As in the findings of this study, other studies have shown that young adult males desire education around the risks of sexual activity if it is delivered in a nonjudgmental and sex-positive way, as STI's were listed by them as a top concern (Davies et al., 2000). When asked what would improve the quality of their sexual health education, participants in other studies have described wanting lessons that are skills-based and address more practical ways of how to have

sex safely (Hilton, 2005; McKay & Holowaty, 1997). On the contrary, literature also supports the finding that a fear-based approach to sexual health education that focuses on the possible negative consequences of sexual activity, rather than a preventive focus, is found to be hindering and unengaging by young males (Collins & Champion, 2009).

Participants in this study also spoke about how a demonstration of how to put on a condom was helpful to the cultivation of their understanding of their own sexual health. In a project conducted by Ray (1998) where she consulted with boys ages 5-16 years about their sexual health education, participants expressed that they often received lessons about why they should use a condom, but what was really helpful for them was to learn how to use a condom. Participants in Ray's (1998) study as well as participants in the current study discussed their fears around not being able to effectively put on a condom during a sexual encounter, and that a condom demonstration was able to boost their confidence and help them to feel more prepared.

Normalization of Male Body, Anatomy and Function of Female Body, Sex Positivity and Normalization, and Consent. These four categories: Normalization of Male Body, Anatomy and Function of Female Body, Sex Positivity and Normalization, and Consent, were grouped together because they are all connected in a larger context within the existing literature. In the current study, 45% of participants expressed that they wished for, and 55% of participants found helpful, discussions that normalized their changing bodies and that addressed how to deal with erections and sexual desire. There was also agreement among participants that it was helpful to learn about the female body; not just its anatomy, but how to give pleasure to females. This naturally leads to the finding that 46% of participants wished to have more education that normalized sexual behavior and that discussed sex as being healthy and pleasurable. Consent was

included in this discussion because consent plays a crucial role in having healthy, consensual sex, and 36% of participants identified it as being a wish list item.

The findings from all four of these categories can be supported by the literature. Concerns about first sexual encounters and how to give pleasure to women were discussed by participants in studies by Hilton (2005) and McKay and Holowaty (1997). In an overview of two studies that investigated how men develop their attitudes toward sexuality and sexual health, Collumbien and Hawkes (2010) discussed how their findings led to the conclusion that the level of understanding of one's own sexuality is what will determine that individual's sexual behaviours. This supports the finding of this study that sex-ed that provided a deeper level of explanation and normalization about the body, sexuality, and sexual relationships was found to be helpful by participants in cultivating an understanding of their own sexuality and sexual encounters.

In other studies that investigated what was found most helpful in a sex-ed curriculum that was designed specifically for young males' in inner city programs, feedback from participants identified "real-life" issues, such as how to deal with sexual urges, how to have sex, and how to be in a relationship (both sexually and emotionally) as being most impactful to them (Ray, 1998; Sherrow et al., 2003; Walker 2001). The young men in these studies highlighted that learning about communication and healthy relationships, especially from a female perspective, influenced them in their future relationships with women, increasing their respect for their sexual partners (Ray, 1998). These concepts lead to a bigger conversation about consent – how to have discussions with a partner before engaging in sexual activity, and how to set and respect one another's boundaries. The finding that consent is a topic that is wished for by participants in the current study is supported by Sherrow's (2003) findings that 90% of their participants reported

that learning about conflict resolution, listening skills, and how to act responsibly and respectfully when engaged in sexual relationships was helpful to them.

Anonymous Question Box, Class Size, and Peer Influence. The three categories: Anonymous Question Box, Class size, and Peer Influence are discussed together because of the way they are linked in a bigger contextual picture in the previous literature. All three categories are fully supported by existing studies. The desire or helpfulness of the anonymous question box is related to the findings that participants felt embarrassment to ask their questions in front of a large class because they feared ridicule from their peers. Thus, the three categories are very closely connected.

Just over one quarter of participants in the current study described having an anonymous question box in their sexual health education as being helpful. They explained that knowing what they were asking was anonymous, protected them from possible teasing by peers. They also expressed that they felt validated when they heard other students' questions that were like their own. In McKay and Holowaty's (1997) study, they found that 80% of their participants preferred an anonymous question box to lead the discussion in their sex-ed class over an instructor's pre-planned lecture.

Forty five percent of the current study's participants identified a small class size or an opportunity to talk with an educator one-on-one as a wish list item. Over one third of participants expressed that they found having a large class size for their sex-ed as a hindering factor. The reasoning was that a smaller group allows for more confidentiality in comparison to a large group. It was again explained that large groups are intimidating to ask questions in front of and there is a fear of being bullied or teased by peers. These findings were embedded in the existing literature as well. In previous studies, participants wanted smaller groups or an opportunity for

one-on-one time with an educator to ask questions because they felt as though that type of environment fostered more respectful listening (Davies, 2000; Hilton, 2005; Sherrow, 2003; Walker, 2001). In these previous studies, male participants expressed a pressure to “know it all” and that the fear of being ridiculed by peers resulted in macho posturing, homophobia, and disruptiveness to deflect negative attention from other students (Hilton, 2005; Ray, 1998) This is consistent with the findings in the current study where participants spoke about peers making homophobic jokes in the classroom and how participants would purposefully not pay attention to the lesson because that was what their peers were doing.

Instructor and Delivery. The category of Instructor and Delivery had the highest participation rate out of all the categories. Having an uncomfortable instructor who did not teach engaging information was seen as a hindering factor by 91% of participants. This study also found that 64% of participants wished for a more comfortable and engaging instructor, and that over half of the participants identified having an instructor who was comfortable and engaging as a helpful factor. Participants expressed that having an instructor who made the topic of sexual health normalizing and who did not contribute to any stigma around sex and sexuality were the most important factors when describing an ideal instructor. These findings are supported by previous research that interviewed students about how they perceived the quality of their sexual health education (McKay & Holowaty, 1997, Byers et al., 2013). Participants in the current study also spoke about how they wanted an instructor who addressed their interests in their sexual health education. They explained that it was difficult to pay attention to instructors who were “boring,” “uncomfortable,” and “off topic.” In their survey of 478 middle school students, where 222 of the participants were male, Byers et al. (2013) concluded that “the extent

to which school-based SHE had covered the topics in which students were most interested was the strongest correlate of their perceptions of its quality” (p. 224).

5.2 Unique Findings

The critical incident categories that are considered unique to this study’s findings and met the minimum 25% participation rate will be detailed in this section.

Critical Incident Findings. To what is known in the current body of literature on young adult males’ evaluation of sexual health education, the critical incident categories from this study that are unique are Gender Identity, LGBTQ Inclusive, and Continuous Education.

Gender Identity. The Gender Identity category is composed of only wish list items, and was the category with the second highest participation rate of all the categories. Eighty two percent of participants wished for discussion around gender identity in their sexual health education to help them with cultivating understanding of gender identity, sexuality, and sexual health. The expectation going into this study was that participants might identify gender identity as a wish list item but in the context of societal expectations of gender roles, such as what it means to be a man. It was a surprise to find that most of the participants wished for education around gender identity so that they felt they could be inclusive and appropriate with their use of language when talking about and addressing others.

Participants acknowledged that they felt uneducated around gender identity, and expressed feeling unsure about what exactly gender identity is and how to speak about it in a “politically correct” way. It was a shared sentiment among participants that they felt gender identity to be a timely topic, that discussions around gender are becoming mainstream and that to be accepting, inclusive, and language-appropriate was expected of them. They spoke about not

wanting to offend others, but also being afraid to ask for clarification or help around the topic themselves, because some participants had experienced backlash from others when they did unintentionally use politically incorrect language. Education around pronoun use and the gender spectrum were the most mentioned aspects of gender identity that participants wished for in their sexual health education.

A few of the participants did acknowledge social gender norms and the prescribed roles that are placed on men and women. They wished that the topic of gender expectations had been introduced earlier in their sexual health education, as it may have relieved some of the confusion they felt about their own gender identity. Two participants shared stories of feeling as though they should identify as female because of the teasing they received from others about their non-traditional interests and activities. These participants expressed that had they learned about the differences between gender identity, sexual orientation, and sexuality at an earlier age, they may have felt more secure and confident in themselves through such formative years as adolescence.

In summary, the topic of gender identity is not a finding that has been shown in previous literature as something young adult males wish they had more education about. However, it is apparent from these participants, that young men do desire to feel prepared and educated around such sensitive and important issues, so that they can be accepting and inclusive to themselves and to others.

LGBTQ Inclusive. The category LGBTQ Inclusive was identified as a wish list item, and the lack of LGBTQ education was found to be a hindering aspect when it came to participants cultivating understanding of their own gender identity, sexuality, and sexual health.

Most of the participants wished they had received sexual health education that was inclusive and normalizing about the spectrum of sexual orientations, same-sex relationships, and

sex practices. It was interesting that participants who themselves identified as straight, wished for education around LGBTQ issues so that they felt more informed about the topic, but more so that their classmates and peers who identified as LGBTQ felt accepted and normalized. Participants who identified as LGBTQ themselves wished for education on LGBTQ issues so that they felt included in the lesson and not “othered”, but also so that they could learn about same-sex practices and how to practice safer-sex.

When discussing not having LGBTQ inclusive sex-ed classes, two participants who identified as gay spoke about not being able to identify themselves within the heteronormative and cisgender prominent dialogue that was used, and how this left them feeling confused and wondering why they didn’t “fit-in” with the “normal” sexual behaviours. Another participant spoke about how not having education around STI transmission and the risks of HIV with anal sex led him to practice risky sexual behaviours. He explained that in the education he received, the dialogue around safer-sex was primarily focused on vaginal intercourse and the risks of unplanned pregnancy, so he thought that condom use didn’t apply to him. Participants who identified as straight also described their heteronormative education as being hindering, because it left them uninformed about varying sexualities and unable to relate to others who did not identify as straight.

Continuous Education. The category of Continuous Education had both hindering aspects and wish list items. When talking about continuous education, participants spoke about either wishing that they had received education that started earlier and had been provided continuously from year to year as they moved through school, or that the fact they did not receive sexual health education on a year to year basis, or at least more often than what they did receive, as being hindering.

When identified as a wish list item, participants expressed a desire to have had more comprehensive sexual health education consistently throughout their public school education. They felt that having sexual health education classes that each year built upon the content from the previous year would have contributed to the cultivation of understanding of their own gender identity, sexuality, and sexual health. They also described how having this type of continuous education may have fostered a more accepting and inclusive environment, and influenced more accepting and inclusive attitudes of themselves and of their peers.

When identified as a hindering item, some participants explained that the little sexual health education they did receive felt like too much information at once, and that they wished it had been broken down into more digestible parts over consecutive years. Other participants expressed that they felt the sexual health education classes they did receive felt like “too little too late” and that the information they had received would have been more helpful at an earlier age. The most common theme in this category, was that participants felt under-educated in general on all aspects of sexuality and sexual health, and that having brief, intermittent, or no sexual health education at all stunted their personal understanding of their own gender identity, sexuality, and sexual health as well as limited their understanding of individuals who identify differently than themselves.

5.3 Implications for Practice

The results of this study have potential implications for educators, counsellors, and other health professionals when working with boys and young men in the areas of gender identity, sexuality, and sexual health. The experiences that were shared by the participants in this study suggest the need for these professionals to evaluate their personal values and judgments, as well

as be proactive in asking their students and clients about their needs and interests. Additionally, school personnel and service providers should be prepared with safe and inclusive referral options for young people with questions and concerns.

Sensing the discomfort of their teachers was the hindering aspect identified most by participants. Participants expressed feeling the awkwardness of their instructor and how this caused them to feel more uncomfortable. Sexual health education can be an awkward subject to teach if it is a topic you are uncomfortable speaking about in general. For this reason, if a professional knows that sexual health may come up in their practice, it is their responsibility to reflect on their personal values and judgements around gender identity, sexuality, and sexual health before attempting to address the subject with students or clients. One way a person can achieve this kind of reflexion is to attend a CAVE/SAR (Comfort, Attitude, Values Evaluation/Sexual Attitude Reassessment). These workshops are run for educators and health professionals by different organizations in the United States and Canada. In Vancouver, BC, Options for Sexual Health offers SAR workshops. They explain their SAR training by stating:

By becoming aware of their values, beliefs, perceptions, and feelings, participants become increasingly comfortable with a wide variation of sexual attitudes, behaviours and practices. This comfort is essential for sexual health professionals, and is also beneficial for individuals striving for personal growth and the development of healthy personal relationships. Participants move toward greater knowing, acceptance and tolerance of the many dimensions of human sexuality (“Human Sexuality Training”, 2016).

There is also training available to become a sexual health educator, as well as workshops and books to become an “Askable Adult” that is designed for any adult to increase their comfort

level on talking to youth about sex. Additionally, the Public Health Agency of Canada (PHOC) has also created the Canadian Guidelines for Sexual Health Education (2008) that is a resource specifically intended to assist educators and health professionals learn about and implement comprehensive evidence-based sexual health curriculum.

The competence of instructors could possibly influence the readiness of students to engage in the materials. It is important that in addition to becoming comfortable with the content, instructors should also have an awareness of topics that are age-appropriate and developmentally-appropriate for students. The importance of this increases as complexities around gender and sexuality continue to evolve in our society. Instructors should be familiar and ready to discuss an array of topics and to answer any questions that may be asked, but when lesson planning it is important to adhere to the guidelines set by the BC Ministry of Education to ensure age-appropriate content.

The reflections of the participants in this study highlight some considerations that may enhance the overall comfort level and effectiveness of discussing sexuality and sexual health. Some participants disclosed a desire for an instructor who is passionate about the topic, is sex-positive, normalizing, and validating to the concerns of the student. Teachers and counsellors can also take the initiative to ask students and clients about topics they are particularly interested in or have questions about and take that into account when planning sexual health education. As wished for by some participants in the study, an anonymous question box that is available ahead of the class can allow for students to “find the right time” to submit their question, maybe when peers or school personnel are not around. Teachers and counsellors could also ask students and clients to fill out questionnaires prior to classes or sessions to gauge the level of prior knowledge to ensure materials are appropriately suited. Professionals can also provide feedback forms after

sexual health classes or discussions that ask for student/client evaluations so there can be improvements in the future.

When working with male clients, educators, counsellors, and health professionals should be keeping the possible fear of asking questions that the findings of this study as well as previous research, suggest at the forefront. In this regard, an important aspect for an educator or counsellor to consider when wanting to introduce discussion around gender identity, sexuality, or sexual health is to do so with sensitivity, and without pressure. They may want to establish an environment where boundaries of confidentiality have been set, offer times when they are available for one-on-one questions, and offer take home resources that include reputable websites, books, or phone lines that offer sexual health information and referrals that the student or client can access anonymously, and on their own time.

5.4 Implications for Further Research

This was an exploratory study about what helps young males cultivate understanding of their own gender identity, sexuality, and sexual health. The intention was to raise questions and considerations that can guide further research and development of sexual health education curriculum. This section will discuss possible areas for future research based on the results of this study.

While results of this study add to our limited understanding of young males' evaluation of their sexual health education, they also identify remaining gaps in the literature. Looking at the contextual findings of this study, it would be interesting and beneficial to see the results of how females and non-binary individuals interpret the terms sexual health education, gender identity, and sexuality. In addition, future research should investigate what females and non-

binary young adults identify as helping and hindering aspects or wish list items regarding their sexual health education. The results of this study combined with the results of these possible future studies could help to develop sex-ed curriculum that effectively addresses the needs and interests of all students.

Since the 91% of participants identified disengaged and uncomfortable instructors as a hindering factor, research that investigates the perspective of educators on this topic could be informative and possibly help develop training programs for teachers to become more comfortable when teaching sex-ed. The unique finding of continuous education being desired by participants is another area to be explored further. In addition to instructors fostering their own sense of comfort around teaching sexual health education, schools and school boards may also need to examine ways in which they can ensure students receive the sex-ed that is prescribed by the BC Ministry of Education from kindergarten through grade 12.

Of particular importance, the unique findings of gender identity and LGBTQ inclusive content were the top two wish list items that resulted from this study. Research is needed to help develop early education in this area to foster an environment of inclusivity and safety for all students within our public schools. For example, future studies might ask students to provide evaluations of sexual health lessons on the topics of gender, gender identity, social norms, and LGBTQ inclusive content to develop age appropriate curriculum that addresses the needs of students in different age groups.

Finally, future research should consider a retrospective study that asks participants these same ECIT questions of what helped, hindered, and was wished for from two points of view: one as their current-self reflecting back, but also what would their answers have been if they were asked these questions at the time and age that they actually received the sex-ed. Another way to

examine this would be a longitudinal study, where students are asked what helped, hindered, and is wished for at the time they receive their sex-ed, and then follow-up with them after they have completed secondary school and have entered adulthood.

5.5 Strengths and Limitations

This study has many strengths related to its inclusion criteria, participant demographics, and research design. Specifically, the inclusion criteria for this study was developed to include any individual between the ages of 18-25 who self-identifies as male. This allowed for a wide variance in male perspectives on sexual health education, specifically gender identity. Participant demographics were diverse in terms of sexual orientation, ethnicity, country of origin, and employment status. Further, this research was the first to utilize an ECIT (Butterfield et al., 2009) to examine young adult males' evaluation of their sexual health education, ensuring a high degree of trustworthiness and rigour, as it employed each of the nine recommended credibility checks. Finally, participants in this study expressed a sense of meaningful contribution by sharing their personal experiences in the hopes of influencing more comprehensive and inclusive sexual health education for future youth.

As was demonstrated when discussing the contextual findings, the amount of sexual health education and when it was received varied greatly among participants. It may be considered a limitation that the sexual health experiences of the participants are so diverse. However, there is also value in bringing attention to this diversity to highlight the fact that all eleven participants did not receive the prescribed learning outcomes of sexual health education that is mandated in the BC Ministry of Education guidelines from kindergarten through grade twelve. This diversity of sexual health education among participants gives more credibility to the

findings that participants wished they had received sexual health education that had started earlier and had continued throughout their school careers.

In addition to the strengths of this study, there are also limitations. The target population of this study was young adult males and as such, results do not speak to the experience of young adult females or individuals who identify as non-binary. Another limitation to the study is that it does not include the perspective of those individuals who have not received any sexual health education. Additionally, all the participants in this study had at least some post-secondary education, possibly influencing results. Because of these factors, as well as the study using a qualitative approach that was constrained by time and budget resulting in a small sample size, the results may not be reflective of the experience of others. Another important element to point out is that participants in this study have all graduated from BC public secondary schools and thus results may be reflective of past elementary and high school students, rather than current BC public school students.

5.6 Concluding Comments

This study garnered many useful insights into the experience of young adult males who received sexual health education in BC public schools and how it influenced the cultivation of understanding of their own gender identity, sexuality, and sexual health. The sharing of their personal stories, reflections, and wishes can contribute and advance the comprehensive sexual health education for future generations, possibly influencing a more inclusive and fair society for all. As one participant aptly stated:

Like, it's great that we're teaching safe sex and all that. That's great. But now we've got to go out further. Because it's evolved. It evolved with how generations go, and social

media, and genders...education has to grow with the times...especially when it comes to sexual health education.

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APPENDICES

Appendix A: Recruitment Poster

A Study Exploring Young Adult Males' Sexual Health Education

The purpose of this research project is to learn from self-identified males age 18-25 years what critical incidents of sexual health education helped, hindered, and were missing, in regards to personal understanding of their own gender identity and sexuality.

The Principal Investigator for this study is Dr. Marla Buchanan, 604-822-4625, Professor at the University of British Columbia. The Co-Investigators for this study are Dr. Norm Amundson, 604-822-6757, Professor at the University of British Columbia; Dr. William Borgen, 604-822-5261, Professor at the University of British Columbia; and Tymarah Cholewa, 604-314-1254, Master's student in Counselling Psychology at the University of British Columbia.

We would be interested in hearing your evaluation of your sexual health education IF:

- **You have received some sexual health education in a BC public school**
- **You are 18-25 years of age**
- **You self-identify as male**
- **You are willing to talk about your experience of sexual health education in a confidential 60-minute interview**

*****ALL PARTICIPANTS WILL RECEIVE A \$25 AMAZON GIFT CERTIFICATE!*****

**If you would like to participate, or would like further information about this study,
please contact Tymarah Cholewa by email at xxx@xxxx.com**

Appendix B: Screening Questionnaire

Screening Questionnaire for Young Adult Males' Evaluation of Their Sexual Health Education: An Enhanced Critical Incident Technique Analysis

Principal Investigator: Dr. Marla Buchanan

Co-Investigators: Dr. Norm Amundson, Dr. William Borgen, Tymarah Cholewa

1. How do you identify your gender?
-If answer is Male, move on to next question. If answer is anything other than Male, they do not meet the inclusion criteria for this study. Thank them for their time.
2. How old are you?
-If answer is age 18-25 years, move on to next question. If answer is anything other than between the ages of 18-15 years, they do not meet the inclusion criteria for this study. Thank them for their time.
3. Did you attend public school in British Columbia?
-If answer is Yes, move on to next question. If answer is No, they do not meet the inclusion for this study. Thank them for their time.
4. During your education in a BC public school, did you receive any sexual health education?
-If answer is Yes, move on to next question. If answer is No, they do not meet the inclusion criteria for this study. Thank them for their time.
5. Are you comfortable speaking, reading, and writing in English?
-If answer is Yes, they meet the inclusion criteria for this study. If answer is No, they do not meet the inclusion criteria for this study. Thank them for their time.

Appendix C: Consent Form



THE UNIVERSITY OF BRITISH COLUMBIA

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CONSENT FORM

“Young Adult Males’ Evaluation of Their Sexual Health Education: An Enhanced Critical Incident Technique Analysis”

Principal Investigator: Dr. Marla Buchanan, Professor
University of British Columbia
Department of Educational & Counselling Psychology, and Special Education

Co-Investigators: Dr. Norm Amundson, Professor
University of British Columbia
Department of Educational & Counselling Psychology, and Special Education

Dr. William Borgen, Professor
University of British Columbia
Department of Educational & Counselling Psychology, and Special Education

Tymarah Cholewa, Master’s Student
University of British Columbia
Department of Educational & Counselling Psychology, and Special Education

This research is being conducted as part of Tymarah Cholewa’s graduate thesis project in the Counselling Psychology MA Program at the University of British Columbia. The results of this research will be included in a master’s dissertation that will become a public document in the University library once completed. The results of this research may also be published in appropriate professional and academic journals.

Purpose

The purpose of this research project is to learn from young adult males' what critical incidents of sexual health education helped, hindered, and were missing, in regards to personal understanding of their own gender identity and sexuality.

Procedures

This study will require one interview and a follow-up contact, with a total time commitment of approximately two hours. The interview will be approximately 60-90 minutes long. Upon giving your signed consent for participation, you will be asked to describe your sexual health education in an open-ended format. You will be invited to discuss events and experiences that made the sexual health education you received more impactful or more challenging to your personal understanding of your gender identity and sexuality. During the final part of this first interview, you will be asked to provide demographic information about yourself. The interview will be recorded, transcribed, and given a code number to ensure confidentiality. Upon completion of the study all audio files will be erased.

The follow-up contact will be a brief discussion on the initial findings and will take approximately 20-30 minutes. Specifically, you will be emailed a 1-2 page summary of the categories and themes that emerged from your initial interview. This will provide you the opportunity to review the summary, so that you can give input, feedback, and comments on the content, meaning, and relevance of these categories and themes to your experience. Your feedback can be discussed via email or telephone, whichever is the most convenient for you.

Confidentiality

Any information identifying individuals participating in this study will be kept confidential. Only the principal investigator and co-investigator will have access to the data. Upon signing the informed consent, you will be given a code number to ensure the maintenance of confidentiality. Participants will not be identified by the use of names or initials in any reports of the completed study. All research documents will be kept in a locked filing cabinet in a locked office at the University of British Columbia. Computer data files will be encrypted and password protected.

Compensation

You will receive a \$25 Amazon gift certificate for your participation. You can withdraw your participation at any time and still receive the gift certificate.

Contact for Information About the Study

If you have any questions or would like more information about this study, you may contact Dr. Marla Buchanan at 604-822-4625, or Tymarah Cholewa at xxx-xxx-xxxx.

Contact for Concerns About the Rights of Research Subjects

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance email RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

Consent

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without prejudice of any kind.

Your signature below indicates that you have received a copy of this consent form for your own records. Your signature indicates that you consent to participate in this study.

Participant Signature

Date

Printed Name of Participant

Thank you for your willingness to participate in this study.

Appendix D: Interview Guide

Interview Guide: Young Adult Males' Sexual Health Education

Participant #: _____ Date: _____
Interview Start Time: _____

Contextual Component 1

Preamble: As you know, I am investigating the ways in which sexual health education have impacted the personal understanding of gender identity and sexuality of young adult males. This interviews purpose is to collect information about the sexual health education you have received in BC public school and how it has influenced you.

1. As a way of getting started, perhaps you could tell me a little bit about your sexual health education (what grades, duration, how it was delivered, etc.).
2. You volunteered to participate in this study because you identified yourself as having received sexual health education. What does “sexual health education” meant to you?
3. You volunteered to participate in the study because you were willing to discuss your personal understanding of your own gender identity and sexuality. What does “understanding of gender identity” mean to you? What does “sexuality” mean to you?
4. On a scale of 0-10, where 0 is a poor understanding of your own gender identity and sexual health, 5 is moderate, and 10 is a high understanding of your own gender identity and sexual health, where would you place yourself currently?

0	1	2	3	4	5	6	7	8	9	10
Low Understanding			Moderate				High Understanding			

Critical Incident Component 1

Transition to Critical Incident questions.

1. Think about a specific experience of sexual health education where you felt your needs and interests around your gender identity/role and/or sexual health were being addressed in a meaningful way.
 - a. Tell me what happened as completely as possible (Probes: what grade, what topics were being discussed, who were the other students in the room, who was the instructor, what was the duration, how was the information delivered, how were the students involved).
 - b. What information was most meaningful or helpful in this experience? (Probes: What was the topic? How was it delivered? Can you give me a specific example? How did the incident/factor help you? What would have been different if you had not had that?)
2. In general, what from your sexual health education was important in helping you understand your gender identity and sexual health/sexuality? (Probes: What was the incident/factor? How did it impact you? Can you give me a specific example or time

when you experienced that? How did the incident/factor help you? What would have been different if you had not had that?)

Helpful Factor & What it Means to Participant (What do you mean by?)	Importance (How did it help? Tell me what is was about...that you found so helpful?)	Example (What led up to the incident. Outcome of incident.

Summarize what has been discussed up to this point with the participant as a transition to the next question:

3. What made it more challenging to for you in understanding your own gender identity and sexual/health sexuality? Alternate question: What other kinds of things happened that made it challenging for you to cultivate understanding of your gender identity and sexual health/sexuality? (Probes: What was the incident/factor? How did it impact you? Can you give me a specific example? How did the incident/factor hinder you? What would have been different if you had not had that?)

Hindering factor & What it Means to Participant (what do you mean by..?)	Importance (How did it hinder? Tell me what it was about...that you found so unhelpful?)	Example (What led up the incident. Outcome of incident.)

Summarize what has been discussed up to this point with the participant as a transition to the next question:

Wish List Component

We've talked about what's helped you cultivate understanding of your gender identity and sexuality, both in a specific example and more generally, and some things that have made it more challenging for you to cultivate that understanding.

1. Are there other things that would have helped you to cultivate this understanding of your gender identity and sexuality? Alternate question: I wonder what else might have been helpful to you? (Probes: What is the wish list item? How would it impact you? Can you give me a specific example? How would this wish list item help your understanding of your gender identity and sexuality? What would be different if you had had that?)

Wish List Item & What it Means to Participant (What do you mean by..?)	Importance (How would it have helped? Tell me what it	Example (In what circumstances might this have been helpful?)

	is about...that you would have found helpful?)	

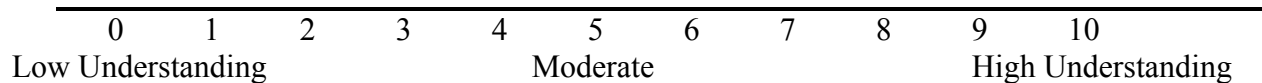
Summary of the Incidents

1. Summarize the factors/incidents and wish list items that were reported (include examples given).
2. Ask the participant if the summary sounds accurate, and if they would like to add new incidents/factors, or make any changes/additions to previously stated incidents/factors.

Contextual Component 2

Now that you've had a chance to reflect back on what's helped and hindered:

1. Where would you place yourself on the same scale we discussed earlier? The scale is from 0-10, where 0 is a poor understanding of your own gender identity and sexual health, 5 is moderate, and 10 is a high understanding of your own gender identity and sexual health, where would you place yourself?



- a. What's made the difference? (To be asked only if there is a difference in the first and second scaling question ratings.)
2. Have you always had a low/moderate/high understanding of you gender identity and sexuality? (Circle one)

YES	NO
-----	----

 - a. If not, when did this change for you?
 - b. What happened that caused you to change your understanding?

Demographics Component

Education level

Employment

Age

What sexual orientation do you identify with?

What race and/or ethnicity do you identify with?

Country of birth

If not Canada, length of time in Canada?

First Language

Interview End Time: _____ Length of Interview: _____
Interviewer's Name: _____

Appendix E: Counselling Resource List

Reduced-Cost Counselling Options in Vancouver

Family Services of Greater Vancouver, Counselling Program - 604-874-2938

www.fsgv.ca/find-the-support-you-need/counselling/ Counselling fees based on household income. Master's-level therapists. Program has a dedicated intake worker who can also refer to other counselling services or groups. Offices in Vancouver, Richmond, Burnaby, New Westminister and Surrey.

Oak Counselling - 604-266-5611 <http://oakcounselling.org/> Reduced fee. Secular counselling services provided at the Vancouver Unitarian Centre by supervised volunteers with Master's degrees in psychology or psychology-related fields. Individual, couples and family counselling.

Adler Centre - Counselling Clinic - 604-742-1818

<http://www.adlercentre.ca/clinic.html> Sliding scale individual and couples counselling. Counselling provided by counselling psychology graduate students at the Adler Centre, supervised by an experienced clinician.

Scarfe Counselling - UBC - 604-827-1523 <http://ecps.educ.ubc.ca/cnps/scarfe-counselling-clinic> Free. Counselling provided by counselling psychology graduate students, supervised by a psychologist. Clinic runs from September to April.

UBC Psychology Clinic - 604-822-3005 <http://clinic.psych.ubc.ca/> Counselling services provided by doctoral student interns, supervised by registered psychologists. \$10-\$40 per hour.

New Westminister UBC Counselling Centre - 604-525-6651 <http://ecps.educ.ubc.ca/clinical-instructional-resources/new-westminister-ubc-counselling-centre/> Free counselling for the general public by counselling psychology graduate students, supervised by a psychologist.

Simon Fraser University - Counselling Clinics Surrey Clinic - 604-587-7320 -

<http://www.sfu.ca/education/centres-offices/sfu-surrey-counselling-centre.html> **Burnaby Clinical Psychology Centre**- 778-782-4720 - <https://www.sfu.ca/psychology/clinical-psychology-centre.html> Counselling for adults, children and youth provided by supervised graduate students in counselling psychology. Services at the Surrey clinic are free and at the Burnaby clinic are offered on a sliding scale.

Living Systems Counselling - 604-926-5496, ext. "0"

<http://www.livingsystems.ca/counselling/locations-fees-services#Counselling> Individual, couple

and family counselling using Bowen Family Systems Therapy. Lower- cost counselling provided by supervised interns.

Heath Initiative for Men (HIM) - 604-488-1001 ext. 230 <http://checkhimout.ca/him-sexual-health-centre/supportcounselling/> Brief professional counselling (8 sessions) is available to gay, bisexual and other men who have sex with men either by donation equivalent to hourly wage. Vancouver, New Westminister, Surrey, Abbotsford.

Qmunity - Free Counselling Program - 604-684-5307 <http://www.qmunity.ca/older-adults/resources/counselling/> Counselling for members of the GLBTQ communities.

Broadway Youth Resource Centre - City University Community Counselling Clinic 604-709-5729 Offers counselling and support services in the areas of youth and family, anger management, and sexual orientation/gender identity issues. Counselling provided by supervised interns completing their Master’s of Counselling Degree. Free.

Surrey Youth Resources Centre, Community Counselling Clinic 604-592-6200 Free counselling provided by graduate student interns for individuals, youth and families (must be have a child or youth it the family to access services)

Vancouver Crisis Line:

Distress Line Numbers:	
Greater Vancouver	604-872-3311
Toll free – Lower Mainland and Sunshine Coast	1-866-661-3311
TTY	1-866-872-0113
BC-wide	1-800-SUICIDE (1-800-784-2433)
Online Distress Services	www.youthinbc.com , www.crisiscentrechat.ca
Seniors’ Distress Line	604-872-1234
Mental Health Support (BC-wide)	310-6789

If you are experiencing a mental health emergency, please call 911.

Appendix F: Sample Email for Follow-up Contact

Dear _____,

Hello and I hope you are well. I would like to thank you again for being a participant in my study. I appreciate your time and willingness and to share your experiences with me. As we discussed, I have attached to this email a summary of the contextual questions I asked you, as well as the helping, hindering, and wish list items that you identified in our interview.

Please read through the summary and let me know if you find it accurate. Consider the following when you read through the summary:

1. Do the interpretations of the terms seem accurate to you?
2. Can you see yourself in this summary/Does this sound like you?
3. Have I missed anything of importance?
4. Is there anything you would like to change, revise, add, or remove from this summary?
5. Do the category titles and descriptions make sense to you?
6. Does the factor you identified seem to fit under the assigned category?
7. Are there any categories that don't appear to fit your factors?

I will make any revisions or edits accordingly.

Thank you again and if you have any questions or concerns please do not hesitate to contact me.

Sincerely,

Tymarah

Appendix G: Critical Incidents and Wish List Items Below 25% Participation Rate

The following helping (HE) and hindering (HI) incidents and wish list (WL) items were identified by participants but did not achieve the required 25% participation rate. For this reason, they were not discussed in the Findings Chapter and are instead included for reference in this appendix.

HE Category: Anatomy and Function of Female Body

Anatomy and Function of Female Body (HI)

Nine percent of participants (1) reported one incident of having learned about the anatomy and function of the female reproductive organs in a sexual health education class and that it was viewed as hindering. The participant stated that this information was delivered in a grade nine sex-ed class and he described feeling “not ready” for the information and that it “didn’t feel relevant” to him.

HE Category: Anonymous Question Box

Anonymous Question Box (WL)

Eighteen percent of participants (2) expressed that they wished there had been an opportunity to ask questions in their sexual health education class via an anonymous question box. One participant expressed that he felt too shy to ask any questions in front of his classmates or to the instructor “because I’m not a person to ask questions in the first place.” Another participant did have an anonymous question box in the room during his sex-ed class, but felt

“like it would have been better if that box was used to kind of direct the class in a way that, like, we'll follow your guy's interests.” He explained that the questions from the box were answered at the end of the class, the answer period was brief, and some questions were not answered. He reported feeling as though the topic that the students really wanted to know about were what is in that box, and instead the lesson focused on other content.

HE Category: Healthy Relationships

Healthy Relationships (HE)

Nine percent of participants (1) described an incident where guest lecturers taught the class about healthy relationships during a sex-ed lesson and how they found this to be helpful. The participant discussed how the guest lecturers acted out skits that depicted scenarios of both healthy and unhealthy styles of communication within romantic relationships, and how he found this to be valuable. Specifically, he found the skit helpful because “I mean it's one thing to hear about it. It's one thing to see it on paper. It's different to actually see it happening in front of your eyes, you know.”

HI Category : Separated by Gender

Separated by Gender (HI)

Eighteen percent of participants (2) identified two incidents where being separated by gender for their sexual health education class was a hindering factor. Participants in this category felt that they missed out on learning about the female body and felt “left in the dark” about the menstrual cycle. “Because I understand that -- like different people's bodies work differently, but then they kind of left us with ignorance about each other.” One of the participants explained that

he relied on information from friends to learn about female bodies and recalled “like even after sex ed, because you didn't go with the girls, it was still kind of like ‘Oh, we don't know how your body works, but we know how like our body works, so I guess I'll just have to assume my friends are right about your body’.”

Co-Ed Sex Classes (WL)

Eighteen percent of participants (2) listed having co-ed sex-ed classes as something they wished they had as part of their sexual health education. Both participants described feeling ill equipped for their first sexual encounters with females, and wished they had better knowledge of female anatomy, and that they had learned alongside females in the classroom. One participant recalled his first sexual encounter and how he felt flustered, “like where’s the clitoris? I had no idea where the hell it was.” He explained there probably would have been better opportunity to learn more about females if females were in the room asking questions. There was also discussion of how not being familiar with the female anatomy led to feeling “in the dark”, and how that could have been remedied if they were taught about the female body with females present. One participant described it as “more of a self-confidence thing”, learning to feel comfortable talking about bodies with the opposite sex. It was also wished for by one of the participants that if the classes were going to be separated by gender, to at least have a review period with both genders together, “going over what we learned and -- which would give us an ability to learn about, like, what we took out of that class instead of like oh, it's 10:30. The girls are coming back. Let's just be quiet and not discuss it or kind of poke fun about periods and all that.”

HI Category: Readiness

Readiness (HI)

Nine percent of participants (1) reported not feeling ready for sexual health education at the time he received it in grade eight and found sex-ed in general to be a hindering factor. He described himself as not being very advanced in terms of puberty and physical maturation so learning about reproduction and safe sex wasn't pertinent. He stated "for me it didn't really matter because I knew I wasn't going to do anything like that...I wasn't -- any sort of ready to do anything like that at that time either. So I think that was probably a challenge, was that I wasn't in that sort of environment where I was -- needed to do that."

HI Category: Lack of Resources

Lack of Resources (HI)

Nine percent of participants (1) described one incident where not having resources or handouts to take home after the sex-ed class was finished as a hindering factor. The participant reported that not being able to review any of the materials learned in class hindered him in being able to retain the information. He explained "There were no hand-outs given, so like even afterwards you couldn't really review it. It was like it's either you watched it, you knew it, or you didn't watch it and you don't know what you're doing."

WL Category: Continuous Education

Continuous Education (HE)

Nine percent of participants (1) described having had continuous sexual health education throughout public school as a helpful factor. The participant received a total of eight or nine

sexual health education classes between the grades four to ten. He reflected that “ It was just helpful how they kept bringing it up over the years, because they, if they, for example, only taught us about it in grade four and then never said a word about it in high school, then a lot of that would have probably slipped my mind and I probably wouldn’t know as much about it as I do now.” The participant believes that the reiteration of the sex-ed content over time is what helped reinforce its importance.

WL Category: Social Media and Critical Thinking

Social Media and Critical Thinking (WL)

Eighteen percent of participants (2) reported wishing they had received education on the topic of social media and critical thinking from their sexual health education classes. Both participants talked about the importance of young people being able to recognize that what is depicted on the internet isn’t necessarily how things are in real life. When asked by the interviewer what specifically they wished would have been covered in their sex-ed class on this topic one participant answered “...how depictions in media aren’t necessarily accurate, because I think that’s something that definitely effects the psychology of a lot of males and females, but especially my generation, because we’re exposed to social media that is highly sexualized.”

Social Media and Critical Thinking (HE)

Nine percent of participants (1) discussed three incidents where he found the topic of social media and critical thinking to be helpful in the sexual health education he received. He talked about the “factors that are affecting kids these days, social media being a big part of that” and the benefit of learning that not everything a person sees or reads on the internet is true. The

class discussion pointed out the reality that “a lot of the time it can be inaccurate.” He also described how this topic wasn’t always talking about social media in a negative light, but also encouraged students to find reputable social media sites that interested them and offered support and resources.

WL Category: Pornography

Pornography (WL)

Eighteen percent of participants (2) reported that they wished they had been educated about pornography in their sexual health education classes. One participant expressed that it would be wished pornography would have been discussed to help normalize that it is used for masturbation. He recalled feeling the desire to know “is it weird that I want to watch porn”? The other participant expressed that he wished that he had known that pornography doesn’t necessarily always depict “real sex” and how it has the potential to give a skewed outlook on women and sex. He explained that now he sees “how women are oppressed from their depictions in pornography” and wishes there had been an opportunity to have a “conversation about how, like, my friends and I would discuss women.”

WL Category: “How-to”

“How-To” (WL)

Nine percent of participants (1) identified learning the actual mechanics of sexual intercourse as a wish list item for sexual health education content. He recalled there being questions about “how does sex work” but when the questions were addressed, they were answered from a reproductive standpoint. He explained that what he really wanted to know was “You know, like I

just feel like the knowledge of it - like what intercourse was and how it worked...I think we should definitely add that into the education process.”