Inclusive Sexuality Education for Children in the Early Years: Perceptions of Family Resource Centre Staff

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Abstract

Children’s sexual development is often ignored in developmental discourse, which can impact a child’s healthy sexual development, inclusion in sexuality education, and their risk of experiencing sexual abuse. There exists in the early years an opportunity to focus on foundational knowledge that will contribute to healthy sexual development across the lifespan. Education and intervention can help to address each risk-reduction (i.e., focus on the potential victim), prevention (i.e., focus on the potential perpetrator), and healthy relationships. However, sexuality education often reinforces hegemony, reflecting elements that serve to reinforce disparities in race, age, ability, gender, sexual identity, and access to knowledge. Whereas family resource centres build family capacity and engage with other community supports in enhancing child development, their perspectives were sought with regards to the provision of family-centered, inclusive sexuality education in the early years. Five family resource centre employees completed an online survey to answer the question of how family resource centres are supporting families in their provision of inclusive sexuality education to their young children. Results indicated gaps existed in opportunities for both pre-service training and ongoing professional development on the topic of children’s sexual development in order to best support families with their children’s healthy sexual development. Furthermore, though resources and materials were indicated, it would appear that there is a need for more developmentally appropriate and inclusive sexuality education materials and resources.
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CHAPTER I

Introduction

“In Early Education considerable emphasis is placed on the holistic nature of young children’s development and learning, how physical emotional, social, and cognitive development are interdependent” (Kakvoulis, 1998, p. 27). However, sexual development is often ignored when considering children’s healthy development. For the purposes of this research, sexual development will be defined as;

“in its broadest sense [sexual development] refers to all aspects of being male or female and the concept has biological, psychological, behavioural, clinical, cultural, social, moral, religious, and educational dimensions. Sexual development is a complex process of changes in human sexuality (biological, psychological and behavioural) that starts from the time of conception and continues throughout the life cycle” (Kakavoulis, 1998, p. 56).

By focusing on sexual development as a process, sexuality can be recognized as an area for lifelong learning, beginning at birth, with many different educators- both formal and informal- including family members, support staff, teaching staff, healthcare professionals, and peers (Angera, Brookins-Fisher, & Inungu, 2008; Borges, Banyard, & Moynihan, 2008). Extending on children’s sexual development, sexuality education is a process of “lifelong learning to acquire knowledge, develop skills, and form positive beliefs, values and attitudes that are incorporated into a person’s self definition and personality”, and one that is culturally sensitive and socially centred (Gougeon, 2009; Walker & Milton, 2006, p. 419). It prepares children for their futures, developing and maintaining relationships with others, making healthy choices and resisting unhealthy
ones, and it provides accurate and appropriate information, and can enhance communication (Aderemi & Pillay, 2013; Kakavoulis, 1998; Kenny, Capri, Thakkar-Kolar, Ryan, & Runyon, 2008). Furthermore, an individual’s self-esteem, emotional growth, and social behaviour may be negatively impacted when a child is not offered access to sexuality education; conversely, inclusion in sexuality education can build a child’s sexual self-esteem, which can help them to understand that they are worthy as sexual beings, and have rights to companionship, love, and protection from harm (Bernett, 2011; Gougeon, 2009; Morales, Lopez, & Mullet, 2011). The present research questions: How are family resource centres supporting families in their provision of inclusive sexuality education to their young children (birth to school entry)?

Most parents want to be their child’s primary source of sexuality education, though they report finding resources to be difficult (El-Shaieb & Wurtele, 2009; Walker & Milton 2006). By supporting parents as sexuality educators, they may feel empowered, which, according to Trivette, Dunst, and Hamby (2010), encourages them to “provide development-enhancing experiences and opportunities” (p. 15) for their children. However, parents can only make choices when they have viable options presented, which highlights the need to help parents as they help their children (Mahoney & Wheeden, 1997). The choices presented should respect and reflect diversity in culture, values, and beliefs, and should recognize parents as key caregivers in their children’s lives (Mahoney & Wheeden, 1997).

“Parents need to be armed with factual information about the severity of the problem, characteristics of perpetrators, the signs and symptoms that abuse has occurred, and
resources to help them prevent, discuss with their children, and seek treatment for Child Sexual Abuse” (Winders Davis et al., 2013, p. 382).

Statistics Canada (2011) found that nearly 55,000 Canadian children experienced sexual abuse in 2009, and research indicates that 30% of child sexual abuse is initiated before the child is six years old (Kenny, 2009; Roberts & Miltenberger, 1999). Sexual abuse is typically rooted in power; examples include males who sexually abuse females or weaker males who may be seen as submissive/feminine, care recipients who are abused by their care providers, and/or adults who sexually abuse children (Dines, 2010; Reid, Reddock, & Nickenig, 2014; Tepper, 2005). Sexual abuse in childhood can have lifelong effects on a child’s “emotional, physical, mental, and spiritual” (p. 307) wellbeing, therefore, early education, intervention, and support can impact children’s healthy sexual development across the lifespan (Gomez, 2011).

Engaging all children in comprehensive sexuality education in the early years (birth to school entry) could impact how children learn to express and receive love and intimacy, changing how power is asserted, ultimately reducing experiences of sexual abuse (Chan & John, 2012; Dines, 2010). It is clear throughout the research that children require sexuality education throughout the lifespan (Lai, 2006). However, barriers exist that may limit access to sexuality education and support, which may be physical (e.g., limited transportation, physical access, and inadequate or inaccessible materials) and/or attitudinal (e.g., stigma, lack of funding, knowledge, and resources) in nature (Aderemi & Pillay, 2013; Porat, Heruti, Navon-Porat & Hardoff, 2012). The impacts of these barriers are significant, as marginalized populations are at increased risk for sexual abuse and having their expressions of sexuality restricted by others who are perceived as dominant
(Lewis, 2004). There is a risk of considering “difference” as an add-on, rather than as an inherent aspect of providing comprehensive sexuality education (Haggis & Mulholland, 2014; Loutzenheiser & MacIntosh, 2004). As such, the following research recognizes that there are multiple, socially constructed, truths from which individuals experience their sexuality and education (Duke & McCarthy, 2009; McPhail, 2004). Removing barriers to healthy sexuality and comprehensive sexuality education can empower all children to explore their sexuality in healthy ways, which encourages sexual wellness and sexual selfhood (Dewinter, Vermeiren, Vanwesenbeeck, & van Nieuwenhuizen 2013; Downing, Jones, Bates, Sumnall, & Bellis, 2011). In order to offer inclusive sexuality education, a commitment must be made to recognizing shortfalls and adopting “new ways of thinking, talking, and practising” (Loutzenheiser & MacIntosh, 2004; Sutees, 2008, p. 16).

**Theoretical Framework**

The research utilized an ecological systems theory to guide research. The ecological systems theory allows for an examination of each intrapersonal (i.e., factors of the individual, including gender, age, development), interpersonal (e.g., family, school, peers), and extrapersonal (e.g., culture, community) factors that impact individuals (Smith & Guthrie, 2001). This theory is reflective of the interactions between an individual’s behaviours and the culture and society of which they are a part (Kenny & Wurtele, 2012). The ecological systems theory will allow for a greater exploration of how children’s sexuality impacts, and is impacted by, many factors, each of which can be considered in the provision of inclusive sexuality education. Furthermore, the ecological systems theory allows for a wider examination of factors that contribute to the
perpetration and experience of sexually abusive behaviours (Dunlap, Golub, & Johnson, 2003).

The ecological systems theory presents limitations. One specific limitation is the challenge of capturing all components of a child’s context and understanding the impact of each (Algood, Hong, Gourdine, & Williams, 2011). In response, the present research intended for family resource centres to represent a broader context for the child’s experiences. Family resource centre staff collaborate with families, community partners, and directly with the children, and are impacted by governmental policies and societal contexts, allowing for a greater understanding of various elements within the ecological systems theory. A second limitation of the ecological systems theory is that using a “nesting” model may not adequately explore how each system interacts directly and indirectly with other systems, indicating that intricacies within and between services and contexts may be minimized or missed (Watling Neal & Neal, 2013).

Method

The current research was intended to identify opportunities for capacity building for both the formal and informal sexuality educators in a child’s life; as such, focus was on how information and support is provided within a family-centered context. Specifically, the research question was posed: How are family resource centres supporting families in their provision of inclusive sexuality education to their young children (birth to school entry)? A needs assessment survey was conducted to identify current practices, existing gaps, and potential solutions for the provision of inclusive sexuality education in the early years. Throughout the literature, there is evidence that family-child communication about sexuality is beneficial in increasing health promoting behaviours.
and reducing the risk of experiencing sexual abuse, reinforcing that “good child sex education evolves from good parent education” (Ballan, 2012; Gabriel and Getch, 2001, p. 288; Murphy & Young, 2005). Family resource centres were surveyed in order to learn about how families are supported in delivering sexuality education to their children. Five respondents participated, all of whom self-identified as female, and all identified the communities they served as rural.

Family resource centres in Nova Scotia serve families beginning with prenatal care, offering a variety of programs, both onsite and in an outreach capacity, such as parent-and-tot groups, parenting groups, transition to school support, and courses such as First-Aid/CPR and infant massage (Maggie’s Place, n.d.). According to the Nova Scotia Council for the Family (2010), there are 37 family resource centres in Nova Scotia, which are situated in both rural and urban communities and serve diverse populations (NS Legislature, 2014). Electronic surveys were distributed to executive directors from each centre, asking them to distribute surveys to all staff members in order to maximize response rates and encourage multiple views of service delivery. It is noteworthy that the surveys were distributed in English only, which may have limited the response rates of those for whom English is not a first language, which may be of particular concern when trying to understand the experiences of families who access Acadian Family Resource Centres or Mi’qmaq Family Resource Centres. Survey questions sought to determine what resources currently exist to support families’ provision of sexuality education to their children. The research intended to find:

- What information, support, and resources do family resource centre staff feel are being asked for by families? When appropriate, to whom are family resource
centre staff referring families for additional support in supporting their child’s sexual development?

- What resources are accessible at family resource centres for families regarding their young children’s sexual development? How do these resources embrace diversity in areas such as culture, ability, sexual identity, and gender?

- What resources are available at family resource centres that directly engage young children (birth to school age) in promoting healthy sexual development? How is diversity in areas such as culture, ability, sexual identity, and gender reflected?

- What education is offered to family resource centre staff to provide information about children’s healthy sexual development during the early years (birth to school entry)? What learning opportunities would be helpful?

Survey responses were evaluated within an ecological systems theory framework, examining how the interactions between family resource centre staff and other elements of a child’s ecosystem can affect their healthy sexual development.

**Limitations**

There were limitations in the research, including a low response rate (n=5), limiting the breadth and generalizability of results. Additionally, the voices of families were not directly included. There is certainly a need to learn information directly from families, and future research would be welcomed in this area. Moreover, respondents were only able to share experiences of families who have accessed supports from the family resource centre, and therefore some families may not be presented.
Findings

Results indicated that family resource centre staff were interested in building their capacity as sexuality educators, and that service delivery varied in terms of teaching materials and strategies, how sexuality education was included in programming, and comfort level with various components of sexuality education. Respondents indicated that families most often asked for support between the ages of three and six years, and were most likely looking for information pertaining to procreation, childbirth, naming body parts, protective methods, and relationships. Some diversity was reflected in programming and materials, though more specific information would be helpful to determine specifically how diversity was portrayed and included in programming.
CHAPTER II

Theoretical Framework

Bronfenbrenner’s ecological systems theory will guide the present research, allowing for a holistic, context-specific, multilevel view of children’s sexual development and sexuality education (Dietrich et al., 2013; Harper et al., 2014). This approach recognizes that children develop within a broader culture, one with multiple, interacting variables, reflecting an opportunity for intervention across multiple tiers, ensuring that approaches are “culturally and developmentally appropriate” (Harper et al., 2014, p. 133;
Padila, Guillermo-Ramos, Bouris, & Reyes, 2010). Specifically the systems described by Bronfenbrenner are the individual level, the microsystem, mesosystem, exosystem, macrosystem and chronosystem, each of which will be detailed and explored for its influence on children’s healthy sexual development and the delivery of sexuality education (Voisin, DiClemente, Salazar, Crosby, & Yarber, 2006).

Individual factors, including gender, age, race, knowledge, and ability uniquely impact children’s sexual development and education (Harper et al., 2014). Although each of these factors will be explored in the literature review as influential on a child’s sexual development and education, it is important to note that each individual factor cannot be teased apart from the other elements, and each is an integral part of a child’s sexual development. As such, the present research will value all individual factors from a sex-positive (highlighting diversity in approaches to, beliefs about, and expressions of, sexuality), intersectionality (recognizing that identities overlap) lens (Oliver, van der Meulen, Larkin, & Flicker, 2013; Williams, Prior, & Wegner, 2013).

The microsystem is the ecological level that immediately interacts with a child and their development, and includes the child’s family, peers, and educators. In relation to sexual development, this system reflects both how children learn about- and experience- sexuality. Family communication greatly impacts the sexual development and sexual behaviours of children; therefore, identifying parents as key influences within a child’s ecological system is important for supporting children’s healthy sexual development (Ballan, 2012; Murphy & Young, 2005). Additionally, “parents need to be armed with factual information about the severity of the problem, characteristics of perpetrators, the signs and symptoms that abuse has occurred, and resources to help them
prevent, discuss with their children, and seek treatment for Child Sexual Abuse” (Winders Davis et al., 2013, p. 382).

The microsystem also encompasses those who perpetrate sexually abusive behaviours against children, as these individuals interact directly with the child (Harper et al., 2014). Whereas an individual cannot be held responsible for preventing their own abuse, focus must shift to the perpetrator and how they can stop perpetrating sexually abusive behaviours. Recognizing common characteristics of abusers can help to understand how to prevent sexuality abuse, highlighting Harper et al. (2014)’s suggestion that “interventions should go beyond basic prevention education and address risk and resilience factors at these multiple levels” (p. 143) within the ecological systems theory.

The child’s community and neighbourhood are located within the exosystem in the ecological systems theory (Dietrich et al., 2013). In Dietrich et al. (2013)’s review of HIV risk reduction in Soweto, South Africa, it became evident that communities guide social norms and practices, which may impact how intervention and support is provided. Community resources can be valuable for families and children, and it is believed that, with support, families and educators can feel more comfortable in their roles as sexuality educators (Suter, McCracken, & Calam, 2012). Examining available community resources and supports can allow for context-specific interventions, which can “create lasting risk reduction” (Dietrich et al., 2013, p. 418).

The macrosystem encompasses beliefs, cultures, laws, customs, resources, and knowledge which impact the society in which the child develops (Dietrich et al., 2013). For example, laws can determine who is allowed to reproduce (e.g., negative eugenics), can enforce a legal age of protection, mandate reporting of sexual abuse, and establish
how sexuality education is provided and by whom (Department of Justice, 2013; O’Brien, 2011; Paranal, Washington Thomas, & Derrick, 2012; Rheingold, Zajac, & Patton, 2012; Saxe & Flanagan, 2013). Beliefs can impact how individual factors (e.g., race, gender, age, ability) are valued, and how sexuality is understood within and between those factors. Available knowledge and resources can impact how sexuality education and sexual development is supported. It is evident that elements of the macrosystem impact both a child’s healthy sexual development and the sexuality education they receive. Therefore, it would seem that intervening within the macrosystem is imperative, while also engaging in culturally appropriate interventions, examining a culture’s values and practices to “highlight the health-promoting aspects of these systems of influence” (Harper et al., 2014, p. 143).

The chronosystem highlights the impact of time on each of the systems. Time can impact both interactions between the systems- as relationships change over time- and can also impact a child directly as they age and develop (Watling Neal & Neal, 2013). The present research recognizes that sexual development occurs across the lifespan, and sexuality education should respond thusly (Parchomiuk, 2012). It is therefore essential that intervention is developmentally appropriate, and also reflective of a changing society, where each element of the ecological system has the opportunity to respond.

The present research will use the ecological systems theory to ascertain how family resource centre staff recognize and intervene at individual, interpersonal, community and attitudinal levels to support children’s healthy sexual development and education (Dietrich et al., 2013). It is clear that no ecological model will be all-encompassing- it is impossible to identify all influences on a child’s development;
however, valuing the child’s development as holistic and entwined within multiple networks allows for a greater understanding of how inclusive sexuality education can be possible (Algood et al., 2011). Watling Neal and Neal (2013) highlighted a limitation of the ecological systems theory, emphasizing systems as being networked rather than nested, and underscoring the relationships within and between systems. In examining how family resource centres support family-centred, inclusive sexuality education in the early years, particular attention will be paid to the mesosystem; the interaction between two microsystems (i.e., the child’s family and the staff at the family resource centre). The family resource centre staff also engage within multiple systems, as their practice is shaped by the macrosystem (including culture, policy, and law), the exosystem (the community in which they are located), and their own microsystem (the families they work with and their colleagues- both within the program and on collaborative teams). These interactions reflect how “multilevel interventions are best equipped to create lasting risk reduction” (Dietrich et al., 2013, p. 418).
CHAPTER III

Literature Review

Many families believe that educating their children about sexual development is important, and most are open to learning strategies to support their children (Kenny & Wurtele, 2012; Roberts & Miltenberger, 1999). As shared by Gabriel and Getch (2001), “good child sex education evolves from good parent education” (p. 288). Throughout the literature, it is clear that parents desire “good education”, as they want to be able to support their child’s healthy sexual development and minimize their child’s risk of experiencing sexually abusive behaviours (Ballan, 2012; Nichols & Blakeley-Smith, 2009). One example, as shared by Ballan (2012) is of a parent stating

“I don’t want someone on the child life study team educating my son about masturbation. I have no idea of that person’s morals, values or skills…but I would like for them to help me to figure out how to best provide the information to my son, so he learns it and I know he gets it” (p. 682).

Although nearly half of parents engage their young children in sexual abuse education, they often do not have access to developmentally appropriate materials such as books, videos, and puppets, which could help children to better understand abstract concepts (Kenny, 2009; Kenny et al., 2008; Tutty, 2000; Walker & Milton, 2006). Those parents who begin dialogue about sexuality in the early years are more likely to continue these conversations throughout their child’s early schooling (Walker & Milton, 2006).

Openness appears to be the most important factor in creating ongoing dialogue with children about sexuality (Murphy & Young, 2005; Walker, 2004). However, parents may be unsure about topics to discuss with their children and how much their children
understand, and may believe that sexuality education may not be pertinent to their child, based on emotional maturity and developmental level (Ballan, 2012; Chan & John, 2012; Nichols & Blakeley-Smith, 2009).

**Rationale**

Many feel that the preschool years is too early to begin sexuality education; however approximately 30% of child sexual abuse is initiated before the child is six (Kenny, 2009; Roberts & Miltenberger, 1999). Statistics Canada (2011) found that almost 55,000 Canadian children experienced sexual abuse in 2009, which seemed to peak around 14 years for girls and from 5-8 years of age for boys. For the purposes of this research, the following definition of child sexual abuse will be used:

“any completed or attempted (non-completed) sexual act, sexual contact with, or exploitation (i.e., noncontact sexual interaction) of a child…included intrusion, child prostitution or involvement in pornography, genital molestation, exposure or voyeurism, the provision of sexually explicit materials, failure to supervise the child’s voluntary sexual activities, attempted or threatened sexual abuse with physical contact, and unspecific sexual abuse” (Chen, Fortson, & Tseng, 2012, p. 622).

Sexual abuse in childhood can have lifelong effects on a child’s “emotional, physical, mental, and spiritual” (p. 307) wellbeing (Gomez, 2011). Effects include post-traumatic stress disorder, depression, personality disorder, anxiety, dissociation, suicidal ideation, aggressiveness, psychosis, social withdrawal, challenges with trust, anger, running away from home, social phobia, poor school performance, behaviour problems, sexual deviance, risky sexual behaviours, sexual dysfunction, sexual precociousness, self-
destructive behaviour (e.g., cutting), suicidal ideation and/or attempts, prostitution, feelings of powerlessness, aggression, teen pregnancy, adult re-victimization, marital problems, eating disorders, alcohol abuse, drug abuse, neurobiological dysregulation, adverse parenting behaviours, stigma, and crime and health problems (Chen et al., 2012; Dunlop, Golub, & Johnson, 2003; Gomez, 2011; Roberts & Miltenberger, 1999; Tutty, 2014; Winders Davis et al., 2013). These symptoms may be lifelong and affect both quality of life and quality of health, and may be exacerbated if children are not supported or believed (Chen et al., 2012; Dickon Reppucci, Jones, & Cook, 1994; Dunlap et al., 2003; Winders Davis et al., 2013).

Children often do not initiate disclosure of sexual abuse (only 42% of girls and 33% of boys do), or do so accidentally (Roberts & Miltenberger, 1999; Tutty, 2000). According to Paranal et al. (2012), “educational personnel, legal and law enforcement, social services staff, medical and mental health practitioners, child day care workers, and foster care providers” (p. 508) were most often responsible for reporting children’s sexual abuse. As with family resource centre staff, many of these positions have a mandate to report suspected sexual abuse, and therefore should be educated in the signs and symptoms of children’s sexual abuse (Rheingold et al., 2012). Symptoms of sexual abuse include, but are not limited to: “sexually transmitted diseases, vaginal or rectal bleeding, abdominal pain, and bruised genitalia…specific sexual behaviour that is inappropriate for their age such as: putting objects into genitals and/or anus, requesting sexual stimulation, and sexual play with dolls” (Roberts & Miltenberger, 1999, p. 2). Additional behavioural symptoms of children’s sexual abuse include “nightmares, disruptive behaviours (e.g., physical and verbal aggression), clinginess, and fearfulness” (Roberts & Miltenberger,
1999, p. 2). Children who experience more severe abuse (i.e., abuse that lasts longer or involves intrafamilial abuse and/or penetration) may demonstrate more serious behavioural symptoms (Roberts & Miltenberger, 1999). When children are not able to communicate effectively, recognizing behavioural symptoms such as “alterations in bowel and bladder problems, appetite, sleep, mood, or behaviours or [they] seem less willing to engage in community participation” (p. 643) of sexual abuse becomes paramount (Murphy & Young, 2005, p. 643).

No individual can be held responsible for preventing their own abuse. However, there are risk-reduction strategies that may lessen the possibility of a child experiencing sexual abuse. These strategies primarily involve establishing foundational knowledge to minimize a child’s risk of being exploited, and include teaching consent, privacy, communication skills, and safety education. Teaching these skills may also address many risk-factors for perpetration, in that an individual can learn the rights of others as they learn of their own rights. Swango-Wilson (2011) identifies the chance to address “prevention, [as] earlier identification, and treatment of sexual abuse or assault” (p. 114) by educating all children. Both risk-reduction (i.e., addresses the potential victim) and prevention (i.e., addresses the potential perpetrator) can be addressed by educating all children, following the philosophy of sexuality education as “life education” (Lai, 2006, p. 2).

The Individual

Sexuality is not given to an individual, it is a part of who they are; as such, no individual should be excluded from “the opportunity to experience their sexuality” (McConkey & Leavey, 2013, p. 182). Inclusion in sexuality education can build a child’s
sexual self-esteem, which can help them to understand that they are worthy as sexual beings, and have rights to companionship, love, and protection from harm (Bernett, 2011; Gougeon, 2009; Morales et al., 2011). According to Bernett (2011), “these rights include participation as sexual individuals with dignity, respect, privacy, equality, and freedom” (p. 129). It is important to also consider the common characteristics of children who experience sexual abuse, which include being passive and trusting, lonely, depressed, appear to have low self-esteem, and may be quiet, lacking in self-confidence, experiencing family difficulties, and/or “have a strong need for attention, affection, and approval” (Ko & Cosden, 2001, p. 58; Roberts & Miltenberger, 1999). Incorporating human anatomy, privacy, consent, legal information, self-help skill development, language development, and social skills can help to ensure comprehensive sexuality education, which can lead to an increase in emotional awareness, disclosure of abuse, and personal safety skills (Barron & Topping, 2013). Specific individual factors (i.e., race, gender, sexual identity, age, ability, and existing knowledge) will be explored below as per how they may impact a child’s sexual development and engagement in sexuality education.

**Race.** According to Lewis (2004), “in identifying risk factors for threats to sexual health, ethnic minority status itself is often identified as a risk factor” (p. 225). Although “it is difficult to separate the effects of [socioeconomic status] on preventive sexual health inequalities from the effects of culturally held beliefs and practices, low health literacy, or structural race-based inequalities such as access to health care” (p. 226), discrepancies in the sexualities of ethnic and racial minorities are evident in African American populations, who experience higher risks of unintended pregnancies, earlier
sexual debut, and higher rates of sexually transmitted infections, including HIV (Lewis, 2004). Specifically, “with particular reference to Black youth in Canada, they account for 7.8% … of the cumulative AIDS cases among youth aged 15–19” (Davis, Gahagan, & George, 2013, p. 2). Although these risks are real, representing the sexuality of racial minorities as “behaviors to be feared and controlled” (p. 231) further stigmatizes individuals and may serve to reinforce, rather than address, vulnerability (Lewis, 2004). Additional stigmatization is referenced throughout the research; for example, a black, sexual woman may be seen as a ‘ho’, rather than as a sexually agentic woman (Froyum, 2010; Lamb et al., 2013). However, according to Davis et al. (2013), “few sexual health interventions directed at or by Black youth exist in Canada and even fewer exist in the Atlantic region provinces such as Nova Scotia, home to the country’s most historic Black communities” (p. 2).

The reinforcement of privilege is seen in wider, cultural conversations which may portray white, middle-class females as sexually vulnerable, and white, middle-class males as heterosexual (Buck & Parrotta, 2014). In contrast, racial minorities were often portrayed as sexually deviant, “bad girls– sexually raw, assertive and immoral”, and their sexuality was focused in preventative rather than pleasurable measures (Buck & Parrotta, 2014; Froyum, 2010, p. 59-60; Lewis, 2004). Froyum (2010) expands on this stereotyped representation, sharing that “policymakers and the media disseminate stereotypical images of black girls as gender deviants who are too sexually expressive and, therefore, unfeminine by middle-class white standards” (p. 61). The author continues, sharing that, whereas policy makers are responsible for determining curriculum, how educators view their students may be reflective of these generalizations and assumptions (Froyum, 2010).
According to the Canadian 2006 census, approximately 4% of Nova Scotians identify within a visibility minority population, which is approximately four times higher than the other three Atlantic provinces (Statistics Canada, 2009). It is clear that race can impact a child’s sexuality across the lifespan, and must be considered in the provision of inclusive sexuality education in Nova Scotia.

**Gender.** Statistics Canada (2015) indicates that 48.7% of 0-4 year old Nova Scotians are female and 49% of 5-9 year olds. Recognizing gender diversity is paramount in early childhood, as children are learning what it means to be male/female, and are internalizing cultural norms and values regarding gender roles, norms, and expectations. This binary of male/female is one that can be exclusionary of individuals who are not cisgender (i.e., individuals whose gender aligns with their sex), and can also limit individuals based on “societal structures of power, privilege, and oppression” (Parent, DeBlaere, & Moradi, 2013, p. 641). Additionally, the information that parents seek about their child’s sexual wellbeing may be impacted by their child’s gender. For example, parents of boys expressed a need for information on masturbation, whereas parents of females more often wanted information on contraceptive use (Dewinter et al., 2013).

Gender differences are clear in child sexual victimization patterns, as females are more vulnerable to sexual victimization than are males, and are significantly more likely to be sexually abused by strangers than are males (Abramson, Boggs, & Mason., 2013; Philander & Swartz, 2006; Statistics Canada, 2011). Though there is limited research available about females as child sexual abusers, it is speculated that their young male victims may “have been socialized to believe that they should be flattered or
appreciative” (Ratliff & Watson, 2014, p. 255) of the attention and/or abuse and/or grooming occurring, and that males who report the abuse may be considered not a “real man” (Wijkman, Bijleveld, & Hendriks, 2010, p. 136). Although gender-based oppression is socially structured, “sexism is real…. The reactions to them, violence, discrimination, and hate, are very tangible” (McPhail, 2004, p. 15), reflecting the impact of gender on both sexual development and sexual education.

**Sexual Identity.** With the relatively recent shift of sexuality education being the responsibility of the school system, schools often perpetuate heteronormativity by ignoring diversity in sexual identity (McCarty-Caplan, 2013). Materials often do not allow discussions about, or materials referencing, diversity in sexual identity. When information about sexual minorities is included, individuals who identify within the spectrum of sexual minorities are viewed as victims, which may serve to pathologize or shame those individuals (Buck & Parrotta, 2014; McCarty-Caplan, 2013). Research shows that youth who identify within a sexual minority experience higher rates of Sexually Transmitted Infections, challenges with school retention, and may not access health care, indicating that the challenges faced by sexual minorities are real, and must be considered in the context of inclusive sexuality education (McCarty-Caplan, 2013). Diversity of sexual identity is also ignored when a discourse of pleasure in sexuality education is omitted; if sexuality is valued only for procreative purposes, all other expressions of sexuality are immediately placed outside the norm (Lamb et al., 2013). It is clear that children’s sexual identity is impacted by their ecosystem, which may have an effect on their sexual development and the sexuality education they receive.
Age. Preschool teachers often felt that sexuality education should begin in the early years (i.e., birth to five), though many felt that the “critical period for sexual development and sex education” was during preadolescence (Kakavoulis, 1998, p. 59). Although all children are capable of maintaining learning over time, younger children appear to learn more than older children from prevention programs, though older children were more likely to retain the skills taught (Chen et al., 2012; Davis & Gidycz, 2000; Leclerc, Wortley, & Smallbone, 2011). El-Shaieb and Wurtele (2009) recommend beginning children’s sexuality education around two years of age, covering topics such as anatomy, birth, and reproduction. Tutty (2014) speculates that young children may not retain information due to social influences such as family, in addition to developmental processes, such as cognitive, social, and moral development. Particularly, children may struggle to remember topics such as blame, non-compliance, and recognizing the difference between intention and behaviour (Tutty, 2000). This speaks to the need for providing ongoing education throughout the formative years, rather than isolating sexuality education to one conversation, colloquially referred to as “the talk” (Tutty, 2000).

Recognizing sexual development as a process, it is clear that children’s sexuality changes in relationship to their age. As stated by Surtees (2008), “children gain protection through learning to evaluate knowledge, rather than by being denied this” (p. 16). This perceived need for protection may create or maintain a sense of children as being inherently vulnerable and in need of protection, and those who do not adhere to the “innocent” script are viewed in stark contrast: as deviant and dangerous (Foucault, 1978; Preston, 2013). Children’s interest in sexuality is often ignored (intentionally or
otherwise) by adults, and therefore children may not be recognized as being “ready” to learn about sexuality.

One example of the impact of age on sexuality education is the trigger of puberty, impacting a child’s access to sexuality education, as knowledgeable others may aim to protect their “childhood innocence” (p. 223), shielding them from healthy learning opportunities (Robinson & Davies, 2008). The opposite may also be true: that puberty may drive parents towards beginning sexuality education, noting a specific milestone impacting sexual development. Additionally, educators’ comfort levels may be impacted by the dissonance between a child’s chronological age and emotional maturity, impacting sexuality education delivery (Ballan, 2012). It is clear that age can impact a child’s sexual development and education in unique and specific ways.

**Ability.** As emphasized by O’Dea, Shuttleworth, and Wedgwood (2012), “certainly chronic illness or impairment, like many aspects of human experience, can have an effect upon sexual expression. This can take numerous paths, including physiological (e.g. sensation, mobility, energy and pain), psychological (self-identity, body image and self esteem), and sociological (concepts of masculinity or femininity, relationships and culture)” (p. 173). This may be of particular importance in Nova Scotia, as Statistics Canada (2008) reports that Nova Scotia has the highest rate of disability (i.e. 4.8% of children 5-14 years of age, compared to the national average of 4%).

Specifically, a summary released by Early Intervention Nova Scotia in 2013 indicated that there are at least 1391 families who qualify for early intervention support for their young children with special needs (i.e., 955 families receiving services, 276 waitlisted for services, and 160 awaiting screening for services (Monaghan, 2013).
An example of how ability may impact sexuality education is that children and youth who are deaf may be less informed about sexuality than their hearing peers. This may be because of barriers to communication, in that both parents and educators may not be proficient in sign language, and are especially lacking in sex signs (Gabriel & Getch, 2001; Getch, Branca, Fitz-Gerald, & Fitz-Gerald, 2001; Job, 2004). Additionally, children with vision loss may miss natural learning opportunities, such as anatomical differences, pregnancy changes, gender expressions/roles/behaviours, and privacy cues, which can impact their sexuality education, as their foundational knowledge may differ from their sighted peers.

Another example of how specific learning styles may impact sexual development and education is in studies of autism spectrum disorder (ASD) and sexuality. Although many children with ASD are interested in relationships with others, they may benefit from support with their sexual development, particular to the “core features of autism… lack of social and communication skills, along with behavioral features” (Ballan, 2012, p. 676; Chan & John, 2012; Dewinter et al., 2013; Nichols & Blakeley-Smith, 2009). Additional characteristics such as “repetitive behavior, stereotyped interests, and sensory fascinations” (p. 310) may lead to inappropriate sexual behaviours such as “compulsive masturbation, possibly with an object, as in fetishism, obsessions with sexual references, or abnormal sexual fears” (Chan & John, 2012, p. 310).

Children with physical disabilities (i.e., those with physical differences or losses which may impact their ability to function physically) may also have unique sexual differences (McCabe & Taleporos, 2003; Murphy & Young, 2005). Due to physiological and/or neurological differences, some individuals with physical impairments may have
altered sensations and arousal patterns as compared to their peers without identified physical disabilities, which could impact erections, vaginal lubrication, pleasure, sensation, and orgasm (McCabe & Taleporos, 2003; Murphy & Young, 2005; Wazakili, Mpofu, & Devlieger, 2006). Children with physical impairments may enter puberty at rates that differ from their peers (Magoon & Meadows-Oliver, 2011; Murphy & Young, 2005). Specifically, while children with Spina Bifida may experience menarche (i.e., their first period) earlier than their peers, and children with Cerebral Palsy may begin their periods later than their peers (Murphy & Young, 2005). This may be because of physiological differences in the central nervous systems, congenital abnormalities, and genetic syndromes (Murphy & Young, 2005). Individuals with physical impairments may also require specific adaptations in how they access gynecological care and perform self-care tasks (Murphy & Young, 2005).

Individuals with disabilities are often not included in the discourse of sexuality education, despite higher sexual abuse rates (Foster & Sandel, 2010; Stewart, 2012). Specifically, estimates suggest that “between 39% and 68% of female children and 16% and 30% of male children with a disability will be sexually abused before they are 18 years old” (Mahoney & Poling, 2011, p. 369). Individuals with disabilities are more likely to experience chronic sexual abuse, either by multiple abusers or on multiple occasions than are their peers (Grossman & Lundy, 2008; Saxe & Flanagan, 2013). According to Sullivan, Bowden, McKenzie, and Quayle (2013), there exists a cultural philosophy of persons with intellectual disability as “naïve and dependent and those who support them are knowledgeable and responsible” (p. 3457), and as such, their “responsibilities, freedom…. and in turn, their interpersonal relationships” are controlled
by “able” others (p. 3457). A belief that individuals with developmental disabilities are “too delayed” to be sexual is often referenced in the literature; however, as shared by Anderson and Kitchin (2000), “virtually nobody is too disabled to derive some satisfaction and personal reinforcement from sex” (p. 1163) (Dewinter et al., 2013). This is echoed by Hingsburger (1993), “we know no parent of a child with disability who does not know with certainty that their child, no matter the level of disability, can love” (p. 8).

The sexual rights of individuals with disabilities have lagged behind their other rights in the process of adopting an inclusive practice (Gougeon, 2010). As shared by Anderson and Kitchin (2000), “many of us find sexuality to be the area of our great oppression. We may well be more concerned with being loved and finding sexual fulfilment than getting on a bus” (p. 1163). Moving beyond a binary of “able” and “disabled” could encourage healthy opportunities for sexuality for all individuals.

There seems to be a movement toward the acceptance of individuals with physical disabilities as parents; however, this acceptance is slower for individuals with intellectual disabilities, indicating a socially constructed hierarchy of disability (Parchomiuk, 2012). This hierarchy of tolerance is further evidenced by the fact that children who have more severe impairments are more likely to be sexually abused (Bowman, Scotti, & Morris, 2010; Mahoney & Poling, 2011). Additionally, even when sexuality education is provided, individuals with disabilities may still be denied access to relationships with others, indicating that there is still much progress to be made in how ability is valued in sexuality discourse (Gougeon, 2010). As a result of biases pertaining to sexuality and disability, it appears that many “adolescents with disabilities are likely to be participating in sexual relationships without adequate knowledge and skills to keep them healthy, safe,
and satisfied” (Murphy & Young, 2005, p. 641). It is essential to recognize that individuals with disabilities are not inherently vulnerable, rather this vulnerability to being sexually abuse is a result of their ecosystem: the individuals within it, the cultural perception of dis/ability, and the legal system, amongst other factors.

**Knowledge.** One additional individual factor that impacts a child’s sexuality is their knowledge base. Children often are unable to discern abusive behaviours, as “sexual abuse is a topic that may require more complex skills than children possess” (Randolph & Gold, 1994, p. 2). Additionally, whereas children may not be able to prevent or discontinue their own abuse, it is important for them to learn skills to safely report abuse, keeping in mind that it is not their responsibility, but could be an opportunity, to prevent their own abuse (Roberts & Miltenberger, 1999). There are many reasons why children may not report being sexually abused, including being threatened, difficulties with selecting a safe individual to report abuse to as they may know the abuser and/or the abuser may be in a position of care or power, they may not be understood due to developing communication and/or language, they may struggle with remembering the event clearly, they may believe they were complicit in the relationship, and/or they may not understand the difference between abusive touch and caring touch (Barron & Topping, 2013; Gill, 2010; Hollomotz & The Speak Up Committee, 2008; Kenny et al., 2008; Rohleder & Swartz, 2009; Tutty, 2000). For example, in a study cited by Kenny et al. (2008), only half of children were able to identify abuse, or describe an abusive event, regardless of their own experience with sexual abuse. Young children may not be able to differentiate between the intention behind a behaviour and the consequences of the behaviour, and thus determine the individual to be “good” or “bad”
based on their behaviours rather than their personality traits (Tutty, 2000). As such, the responsibility should fall those who are capable of understanding abstract thought, such as parents and educators, to identify good and bad, and appropriate and inappropriate behaviours (Roberts & Miltenberger, 1999). Responsibility for prevention of sexual abuse is often given to the victim, which is colloquially referred to in popular culture as “victim-blaming”, and asserts that the individual is responsible for preventing their own abuse (Dickon Reppucci et al., 1994). Although several programs are “aimed at teaching children to avoid and report abuse”, it is unfair and unrealistic to place this responsibility on a child, especially as they may not be developmentally able to understand the event as abusive, nor have the ability to deter the abuser (Davis & Gidycz, 2000, p. 257; Kenny et al., 2008; Winders Davis et al., 2013). However, because of their egocentric thinking, young children are not yet able to recognize the views of others, and often blame themselves for the abuse (Chen et al., 2012; Kenny et al., 2008). It is clear that a child’s knowledge, whether absent or in/accurate can impact their sexual development and education, as comprehensive sexuality education is found to increase knowledge, skills, and health promoting behaviours, and may contribute to the prevention of sexual abuse (Aderemi & Pillay, 2013; Harper et al., 2014; Kenny et al., 2008; Lamb et al., 2013).

Sexual abuse prevention programs are typically intended to teach skills to children to avoid or reduce abuse, which may include teaching self-defence, consent, leaving the situation, disclosure and reporting of abuse, recognizing secrets, feelings and intuition, support systems and safe persons, acceptable and non-acceptable touch, body awareness, assigning guilt, and bullying (Ko & Cosden, 2001; Leclerc et al., 2011; Tutty, 2014). Such programs demonstrate success in increasing children’s abilities to identify
and report abuse, thereby decreasing sexual abuse rates of children (Barron & Topping, 2013; Davis & Gidycz, 2000; Kenny et al., 2008; Leclerc et al., 2011). Offenders interviewed in a study cited by Leclerc et al. (2011) shared that “the victim was sometimes able to prevent the abuse from occurring by using self-protection” (p. 1874).

Understanding privacy allows children to recognize that they have control over their own bodies and that they have the right to decide where and when they touch others, are touched by others, are naked, or are having conversations about personal matters (Hollomotz & The Speakup Committee, 2008; Rashikj & Trajkovski, 2009; Sakellariou, 2012). “Students excluded from accessing a curriculum that teaches them about their rights and responsibilities are more apt to have those rights abused” (p. 286), reflecting the importance of individuals understanding consent (Gougeon, 2009). According to Kenny et al. (2008), “knowledge of the correct terminology for genitals is deemed critical to others’ response to children’s disclosure as abuse” (p. 37) (Barron & Topping, 2013; Brown & Turk, 1994; Kenny et al., 2008). Moreover, perpetrators rarely abuse children who know the correct names for their genitalia and are aware of appropriate/inappropriate touch, which may be because perpetrators know that those children have specific language to report their experience (Kenny et al., 2008). Equally important, having language about the body can enhance sexual selfhood, and allow children increased access to sexuality education and knowledge.

There is some hesitation in the provision of sexuality education for young children, including reservations that children are not cognitively able to understand the concepts, may endure nightmares, have increased anxiety and externalizing behaviour problems, experience changes in eating and sleeping, over-generalize or over-react,
demonstrate changes in physical affection, and show increases in sexualised behaviour (Kenny et al., 2008; Lai, 2006; Roberts & Miltenberger, 1999; Tutty, 2014). Although these symptoms are minimally evident, appearing in approximately 5% of children who participate in sexual abuse prevention programs, these problems may persist (Roberts & Miltenberger, 1999; Tutty, 2014). However, parents who indicated that their children were fearful after receiving sexuality education also indicated that the education was ineffective; therefore, it is possible that these problems may be a direct result of how sexuality education is approached (Davis & Gidycz, 2000; El-Shaieb & Wurtele, 2009; Gougeon, 2010). Moreover, it is believed that, by following developmentally appropriate practice, these concerns should be abated (Kenny et al., 2008).

**Microsystem**

Sexuality education should be offered both formally and informally to all children, and “taught within the context of human relationships” (Nichols & Blakeley-Smith, 2009, p. 73). As stated by Kalyva (2010), “the question is not if individuals with autism will receive sexuality education, but how it will be offered” (p. 436), a sentiment which can be applied to the sexuality education of all children. The way sexuality education is provided, it at all, may be impacted by societal beliefs, which parallels how inclusion is embraced, as the delivery of an inclusive curriculum is impacted by an educator’s beliefs, values, and understandings (Glazzard, 2013; Magoon & Meadows-Oliver, 2011). Specific to children’s sexual development and sexuality education, the following elements of the microsystem will be explored: family, professionals, peers, and perpetrators.
Families as Sexuality Educators. Parents are typically invested in their children’s healthy sexual development, and are likely to take long-term responsibility of their children, offering learning opportunities for “decision making, values, dating, body image, peer pressure, self-esteem, safe sex, and personal safety” (Ballan, 2012; Cox, Scharer, Baliko & Clark, 2010; East & Ochard, 2014, p. 346). Before puberty, parents are the most prominent source of sexuality education, and it is believed that mature sex education is most effective if parents are valued early on as primary sources of sexuality education (Cox et al., 2010; East & Orchard, 2014; Povilaitienë & Radzevicienë, 2013; Rashikj & Trajkovski, 2009). Parents are able to discuss sexuality with their children more often and more regularly than are professionals, and can make use of naturally occurring learning opportunities, reinforcing learned skills (Dickon Reppucci et al., 1994; Kenny, 2009; Kenny et al., 2008; Roberts & Miltenberger, 1999; Walker, 2004). It is important to acknowledge that parents already provide sexuality education through role modelling of desired and appropriate behaviours (Angera et al., 2008). Parents reported finding it easier to initiate sexuality education dialogue in the early years, and children who were engaged in early sexuality education from their parents were more likely to continue the dialogue into later years (El-Shaieb & Wurtele, 2009; Walker, 2004). Parents who conversed more frequently on the topic of sexuality were viewed as more comfortable by their children, and parents who were viewed as more “askable” had children who were considered to be more confident about sexual matters (Angera et al., 2008; Walker, 2004). Family communication greatly impacts the sexual development and sexual behaviours of children (Ballan, 2012; Murphy & Young, 2005). In fact, research shows that parental communication can increase condom use and decrease risky
sexual behaviour, including having multiple partners, and frequent intercourse (Angera et al., 2008; Cox et al., 2010; Walker, 2004; Walker & Milton, 2006). Parents often report feeling uncomfortable educating their children about sexuality, as they feel unprepared, embarrassed, unskilled, fearful, and may lack confidence or clarity in their values (Job, 2004; Kenny, 2009; Lai, 2006). As a result, parents may provide inaccurate information, may use inadequate or unreliable resources (e.g., the media), and may ignore primary perpetrator populations (e.g., other family members) when discussing abuse (Kenny et al., 2008; Povilaitiené & Radzeviciené, 2013; Tutty, 2000).

Oppression based on gender can be seen within the microsystem in responses to mothers whose male partners sexually abuse their children. Although most child sexual offenders are male, much of the blame falls to the mothers for not protecting their children; however, McLaren (2013) shared that fathers who sexually abuse their child(ren) “premeditate, plan and purposely undermine the relationship between the mother and child” (p. 442), thus encouraging trust and secrecy with the child, and limiting the child’s relationship with the mother. Blaming mothers supposes that “good” mothers would know if their children are being sexually abused, which serves to reinforce hegemony, because “privilege of the man and oppression of the women happen in tandem” (McLaren, 2013, p. 442). In response, mothers often fear the stigma associated with having an abusive partner, reinforcing the heteronormative idea that females should be able to be able to both “protect their children…[and] manage their adult relationships” (McLaren, 2013, p. 445). However, this practice of shaming and judging mothers may hinder their willingness to report abuse, which further places children at risk of sexual abuse perpetrated by fathers or father figures (McLaren, 2013).
This misplaced blame is reminiscent of children being blamed for not preventing their own sexual abuse, redirecting attention away from who is at fault: the perpetrator. “They continue to focus on mothers’ silence as indications of the ‘failure to protect’ without acknowledging the contribution of men’s psychological and physical power over the child, his partner, and the community around them” (p. 445-446).

Families who did engage their children in conversations about sexual abuse tended to be more educated and had personal experience with children’s sexual abuse, be it as an acquaintance of a victim, or as a victim themselves (Kenny et al., 2008). Dickon Reppucci et al. (1994) shared several reasons why parents are effective in sexual abuse prevention of young children: children are comfortable with- and trust- their parents, parents know their children best and therefore know how their children learn and how best to teach them, and last, parental intervention can begin earlier than can community programs. Additionally, according to Kenny (2009), educating parents can help the topic of children’s sexual abuse to be less secretive (Roberts & Miltenberger, 1999). Parents may underestimate their child’s risk for sexual abuse, and overestimate their child’s knowledge and protection skills (Roberts & Miltenberger, 1999). Additionally, Roberts and Miltenberger (1999) indicated that parents often felt that they would “just know” if their child experienced sexual abuse. If parents are educated on abuse prevention strategies, they are more likely to engage their children in dialogue; therefore, parents should be educated in symptoms, signs, and strategies for the prevention of sexual abuse, as well as tools for supporting their children’s healthy sexual development (Dickon Reppucci et al., 1994; Roberts & Miltenberger, 1999).
Within the microsystem, families impact their child’s sexual development and sexuality education, and they could benefit from support with determining the content of parental discussions (Cox et al., 2010). It is important that sexuality education is valued as a shared responsibility between professionals (including educators, medical professionals, etc.) and families, reflecting the family’s “beliefs, wishes, and concerns” (Ballan, 2012; Nichols & Blakeley-Smith, 2009, p. 74).

**Professionals as Sexuality Educators.** Educators’ attitudes are essential to providing a meaningful curriculum, as is the value they place on the topic, their intent to teach it, and their comfort level with the subject matter (Bowden, Lanning, Pippin, & Taner, 2003; Gougeon, 2009). Sexuality education should be both active and engaging, using a naturalistic and contextualized approach, allowing for generalization, encouraging learners to implement what they know across environments, experiences, and people (Lumley, Miltenberger, Long, Rapp, & Roberts, 1998; Miltenberger et al., 1999; Walker, 2004; Wilcox, 2004). In order to provide effective sexuality education, educators must be equipped with “relevant information, good relations with the child, and personal characteristics such as maturity, modelling, self-respect, and morality”, they should be interested in the topic, be familiar with the subject, and be able to communicate effectively with their learners (Getch et al., 2001; Kakavoulis, 1998, p. 62; Menmuir & Kakavoulis, 1999). According to Kenny et al. (2008), most families felt that children should receive sexual abuse prevention education in a childcare setting.

Classroom teachers can be valuable resources in providing sexuality education to students, as they have access to information and resources, and can promote an inclusive learning environment, teaching acceptance, diversity, and inclusion, and challenging
prejudice and “otherness” (Duke & McCarthy, 2009; East & Orchard, 2014; Fader Wilkenfeld & Ballan, 2011). Elementary school is frequently the starting point for formal sexuality education, because of convenience, knowledge of children’s development, established relationships with students, and an increased likelihood of identifying and reporting sexual abuse (Chen et al., 2012; Randolph & Gold, 1994; Roberts & Miltenberger, 1999). Similarly, family resource centres are familiar with their community, child development, and build relationships with families and children, indicating that they can adopt a significant role in the delivery of sexuality education in the early years. Like family resource centre staff, school and preschool personnel are typically well positioned to support children’s sexual abuse prevention, identifying signs and symptoms of abuse, responding to allegations and disclosures, reporting to the proper authorities, and providing information on community resources and supports (Kenny et al., 2008; Lai, 2006).

It is important to acknowledge the fears and apprehensions of educators, as Bowden et al. (2003) found that “even an effective program cannot impact children’s sexual abuse prevention if individuals are unwilling to engage in and complete the training” (Rheingold et al., 2012, p. 424). It is clear that pre-service training and professional developmental opportunities are both lacking and necessary in order to support sexuality education of children (Dune, 2012; Lai, 2006; Mahoney & Poling, 2011; Payne & Smith, 2014). Although teachers may be supported in declining to teach sexuality and relationship education, it is believed that with support, they can feel more comfortable teaching their students (Suter et al., 2012).
**Peers as Sexuality Educators.** Peers play an essential role in children’s sexuality. Whereas one study found that sixty-one percent of teens were more likely to access information from their peers than their parents, it can be valuable to use peers as educators, while also ensuring both have accurate information (Angera et al., 2008). Walker’s (2004) research into sexuality education found that “peer involvement appears to increase confidence about communication about sexual matters, enabling positive changes and sexual knowledge and beliefs about future sexual behaviour, and confidence in relationships” (p. 247). It is therefore essential that a move toward full inclusion is embraced in order to address both the imminent learning needs of children and to remove the social barriers (Gougeon, 2010).

**Perpetrators of Sexualized Violence.** Perpetrators of sexualized violence are also an element of a child’s microsystem, as they directly impact the sexual development of the child; therefore, attention must be paid to the characteristics and behaviours of perpetrators. According to Roberts and Miltenberger (1999), nearly half of child sexual abusers are not yet twenty years old, demonstrating a need to address possible high-risk behaviours during the early years. In fact, Burn and Brown (2006) note that the younger the age of the perpetrator, the more persistent their sexual exploits. In following a social-constructivist approach, it is believed that children may be socialized into abusive roles, indicating opportunities to teach appropriate expressions of sexuality, rooted in dignity and respect for self and others (Dines, 2010). Children who had experienced sexual abuse indicated the following warning signs of potential perpetrators;

“the abuser provided differential treatment of the victim compared to other children, the abuser told the victim not to tell anyone about anything the two did
(abusive or not), the abuser "accidentally" entered into bathrooms and bedrooms when the victim was undressed, the abuser "accidentally" touched the victim's private areas, the abuser granted extra privileges to the victim, and the abuser purposely kept all doors open” (Roberts & Miltenberger, 1999, p. 12).

Child sexual offenders are often university educated, single, psychologically stable, are able to hide their interest in children, and often do not have prior criminal offenses (Abel, Jordand, Handa, Hollanda, & Phippsa, 2001; Ratliff & Watson, 2014). Perpetrators of children’s sexual abuse are predominantly male, regardless of the gender of the children they abuse, though Proeve (2009) found that offenders who had male victims tended to also have female victims (Burn & Brown, 2006; Roberts & Miltenberger, 1999). Female sexual abusers are estimated to make up about 5% of the offending population, though it is unclear how much of their abuse is perpetrated against children (Wijkman et al., 2010).

It was indicated by Denov (2004) that female-perpetrated sexual abuse is often perceived by professionals such as social workers and law enforcement officers as “less harmful” (p. 1138) than abuse perpetrated by men, minimizing the experiences of victims. Female sexual offenders are likely to have experienced physical and/or sexual abuse in their childhood, and often have a male co-offender (Goldhill, 2013; Wijkman et al., 2010). Furthermore, they are very likely to have lower intelligence and have poorer mental health than females who do not perpetrate sexual abuse (Goldhill, 2013; Wijkman et al., 2010).

In a study shared by Burn and Brown (2006), perpetrators of child sexual abuse “viewed sex with a child as less threatening than sex with an adult in 41% of cases” (p. 230), and cited their sexual needs as their primary reason for offending, and the
emotional connection secondary. According to Burn and Brown (2006), child sexual abusers typically feel attracted to the children they abuse, and use “grooming” behaviours (i.e., gradual and progressive behaviours used by perpetrators to lure children into sexual abuse). Children may not recognize this desensitization/grooming process, and often feel that they have complied with the relationship, further highlighting the aforementioned developmental challenge of children recognizing the differences between an individual’s intent and their behaviour (Roberts & Miltenberger, 1999; Tutty, 2000). Burn and Brown (2006) noted that perpetrators were likely to use grooming behaviours that have been effective in the past, 19% of abusers identified using physical force as their primary grooming behaviour, and 56% of perpetrators were unsure what impacted their choices in grooming strategies.

There is often a perception of perpetrator and victim as separate entities; however, whereas many perpetrators of sexually abusive behaviours experienced sexual abuse in their own childhood, challenging this division and considering shared learning opportunities can help to teach children skills that can support healthy expressions of sexuality (Burn & Brown, 2006). According to Lonsway et al. (2009), risk-reduction focuses on giving skills to the victim to reduce their likelihood of experiencing sexual abuse, whereas prevention examines how to prevent individuals from engaging in sexually abusive behaviours. Although Ratliff and Watson (2014) indicate that perpetrators of sexually abusive behaviours are largely male (~88%), in keeping a feminist lens, it is essential to consider that

“men are socialized by the culture into a specific type of masculinity…. If we take seriously the notion that we are all cultural beings, then we need to think about the
ways that boys become men and how this process creates a consumer base […] that is degrading to women. …the type of masculinity a boy adopts will depend on multiple factors such as religion, race, and class, the dominant masculinity today is […] one in which “men are assumed to be naturally competitive, and aggressive”” (Dines, 2010, p. 59).

Sexual abuse of children is often under-reported, which may be due to reasons including children choosing not to disclose, or care providers choosing not to report abuse (Winders Davis et al., 2013). Caregivers likewise may choose not to report abuse because of their own comfort level and their own relationship to the perpetrator (Winders Davis et al., 2013). Children younger than eighteen years of age knew their abuser in approximately 85% of abuse incidents, whereas their family knew the perpetrator in approximately 70-90% of abuse instances (Chen et al., 2012; Roberts & Miltenberger, 1999; Statistics Canada, 2011; Winders Davis et al., 2013). Children younger than three years of age were more likely to be sexually abused by a parent (i.e., 8 in 10 victims), numbers which seem to decrease with age (e.g., 60% of 3-11 year old victims, and 55% of 12-17 year old victims), and females were four times more likely to be sexually abused by a family member than males were (Statistics Canada, 2011). Of preschoolers who experience sexual abuse, 72% is perpetrated by a family member, and for school aged children, 73% are abused by someone outside of their family (Roberts & Miltenberger, 1999). Sexual offenders tended to perceive their experience as beneficial to the children, and may “deny, minimize and/or rationalize [their] behaviour” (Burn & Brown, 2006, p. 227). These statistics reflect the importance of considering the child’s microsystem when examining sexual development and sexuality education.
Exosystem

The exosystem encompasses a culture’s mass media, and education, governmental, and economic systems. This particularly effects how service is delivered, directly impacting the provision of sexuality education in the early years. For example, Nova Scotia’s Department of Education and Early Childhood Development is directly responsible for determining policies, programming guidelines, and curriculum, for childcare programs, public schools, and family resource centres. In order to understand the impact of the exosystem in context of curriculum development, abstinence-only education and comprehensive sexuality education will be reviewed.

Many parents and educators feel that children would benefit from an abstinence-only curriculum, focusing on delaying sexual activity until marriage (McCarty-Caplan, 2013). The objectives of abstinence-only education include touting the benefits of abstaining from sexual activity, teaching sexuality as only appropriate within marriage, highlighting the effectiveness of abstinence in preventing unintended pregnancies and STIs, and teaching the “harms” of premarital sex (Froyum, 2010; Trenholm et al., 2008). Abstinence-only education is typically rooted in heteronormativity, asserting that the “normal” or “natural” relationship is a male/female one, as marriage has historically been reserved for heterosexual couples (McCarty-Caplan, 2013).

Additionally, abstinence-only education tended to focus on the ineffectiveness of birth control methods (Kohler, Manhart, & Lafferty, 2008). Abstinence-only education demonstrated an impact on knowledge, attitude, beliefs, and intentions, and has shown some benefits to HIV/AIDS prevention in Africa (Aderemi & Pillay, 2013, Trenholm et al., 2008). However, abstinence-only education did not appear to impact behaviour or
abstinence long term, nor did it show marked differences in delaying first intercourse, decreasing number of sexual partners, decreasing risk of sexually transmitted infections (STIs) or unintended pregnancies, as compared with control groups who received no formal sexuality education (Kohler et al., 2008; Trenholm et al., 2008; Walker & Milton, 2006). Research also indicates that abstinence-only learners who were sexually active were less likely to use condoms during their first sexual encounter (Kohler et al., 2008; Trenholm et al., 2008). Therefore, research seems to favour embracing a comprehensive sexuality education program (Denny & Young, 2006; Kohler et al., 2008; Trenholm et al., 2008).

Comprehensive sexuality education appears to be more inclusive, sex-positive, and more reflective of the reality of sexuality (McCarty-Caplan, 2013). The goals of comprehensive sexuality education include supporting healthy living and developing positive attitudes in order to promote healthy relationships (Kakavoulis, 1998). Sexual health was described as “an outcome of a positive sexual development” (Dewinter et al., 2013, p. 3468). Sexual health education can help an individual “feel able, and [be] able, to make assured, informed, and confident sexual decisions to mediate positive sexual behaviours” (Downing et al., 2011, p. 809). Possible topics in a comprehensive sexuality education program include anatomy and physiology, respect for self and others, safety skills, and relationship skills (Davis & Gidycz, 2000; Downing et al., 2011; Getch et al., 2001; Kakavoulis, 1998; Kenny et al., 2008; Lai, 2006; Matziou et al., 2009; Tutty, 2000). In order to promote healthy sexuality, education must move beyond skills and knowledge, instead giving consideration to positive aspects of sexuality, including decision making, dating, sexual-identity, marriage, “the importance of touch, intimacy,
relationships, and sexual exploration” (East & Orchard, 2014, p. 336; Preston, 2013; Saxe & Flanagan, 2013; Swango-Wilson, 2010). Comprehensive sexuality education should be individualized to ensure that it supports a child’s developmental and psychological levels, should be non-biased, and should include “acquiring knowledge, developing skills, and forming positive behaviours, values and attitudes” (Walker & Milton 2006, p. 419), and emphasize communication and exploration of “values, goals and options” (McCarty-Caplan, 2013, p. 253) (Matziou et al., 2009; Roberts & Miltenberger, 1999; Suter et al., 2012).

Comprehensive sexuality education is found to increase knowledge, skills, and health promoting behaviours such as later sexual debut and increased condom use (Aderemi & Pillay, 2013; Kenny et al., 2008). Teaching about condoms and HIV/AIDS does not appear to increase sexual activity; rather, comprehensive sexuality education for youth reduced unintended pregnancies as use of birth control increased (Aderemi & Pillay, 2013; Kohler et al., 2008). Likewise, children who participated in comprehensive sexuality education programs recognized that both females and males can be victims, knew that perpetrators may be individuals with whom they have a pre-existing relationship, reported feeling safer and more in control, and felt better about self-pleasure and their bodies (Kenny et al., 2008; Ko & Cosden, 2001). When asked about topics to be included in young children’s sexuality education, preschool teachers suggested body awareness, gender awareness, genital function, respect of relationships between genders, protection from harm, development of respect, emotional development, love, communication, fidelity, interpersonal relationships, justice, and dignity, with the intent to promote lifelong learning in children (Kakavoulis, 1998; Menmuir & Kakavoulis,
Kenny (2009) and Kenny et al. (2008) echoed aspects of this list, indicating that preschoolers should learn body awareness, gender differences, abuse-response skills, and personal safety skills. El-Shaieb and Wurtele (2009) elaborated, highlighting topics specific to five to nine year olds, including reproduction and childbirth, body awareness, gender differences, interpersonal relationships, sexual identity, sexually transmitted infections, and contraception. It is clear that comprehensive sexuality education for all children can help to address both sexual abuse and healthy sexuality across the lifespan.

Additional factors within the exosystem which may impact sexual development and education include religion and media, as these two factors impact- and are impacted by- the community. Related to the impact of media on sexuality education and sexual development, many teens cite entertainment media as their primary source of sexuality education, and although many parents indicated the impact of peers and media on their child’s sexual development, they did not necessarily use these influences to guide or initiate dialogue, nor did they report feeling comfortable questioning to find out the accuracy of the information received (Angera et al., 2008; Cox et al., 2010). According to Haglund and Fehring (2010), religion can be a “protective factor that appears to contribute to decreased sexual risk behaviours”, including multiple partners and age of first intercourse (p. 460). Specifically to religion, in Nigeria, due to religious values, the limited provision of condoms has impacted education around safe sex practices (Arademi & Pillay, 2013). Additionally, sex outside of a marriage may be viewed as sinful and therefore discouraged, which may impact individuals who may be discouraged from marrying (e.g., sexual minorities, individuals with disabilities) (Wazakili et al., 2006; Rohleder & Swartz, 2009). According to the 2001 Canadian census (Statistics Canada,
2005), 87% of Nova Scotians identify within a Christian sect, 12% identify having no religious affiliation, and 1.13% identify as other religions (e.g., 0.2% Jewish, 0.4% Muslim, 0.2% Buddhist, 0.1% Hindu, 0.03% Sikh, 0.06% Eastern, 0.1% other). Recognizing and respecting religious diversity is essential to the provision of inclusive sexuality education.

The role of sexuality educator can be difficult as the balance of providing comprehensive education to students and respecting the expectations of families and staff is precarious, reflecting a need for administrative support in adopting inclusion policies that reflect diversity in gender, race, culture, ability, and sexual identity (Sausa, 2005; Suter et al., 2012). The role of the government, media, economic system and religion system impact how sexuality education is valued and presented in communities, impacting a child’s healthy sexual development across the lifespan.

**Macrosystem**

The macrosystem encompasses policies and cultural values that impact each element within the child’s ecosystem. According to Matziou et al. (2009), teaching and learning “can be influenced by religious values, teaching sources, socio-historical context, perceptions and gender differences” (p. 358), therefore, sexuality education must be viewed through a lens allowing for multiple views. Challenging the culture’s gender socialization practices could impact a child’s developing sexuality, as shared by Dines (2010); “If we take seriously the notion that we are all cultural beings, then we need to think about the ways that boys become men” (p. 59). By selecting a sexuality education program that is “developed from multiple informed perspectives” (p. 263) there is an increased likelihood that the curriculum will be “inclusive of difference and sensitive to
the complexity of addressing the intersections between sex, sexuality, identity, inequality and health” (McCarty-Caplan, 2013; p. 263).

There exists in society a “hierarchy of tolerance…some forms of difference and diversity are more readily responded to than others” (Surtees, 2008, p. 15). In order to challenge these socially-constructed “norms” and move towards inclusion of all individuals in accessing sexuality education, a commitment must be made to recognize these shortfalls, and adopt “new ways of thinking, talking, and practising” (Loutzenheiser & MacIntosh, 2004; Sutees, 2008, p. 16). In order to provide inclusive sexuality education for all individuals, examining “the root causes of disparities in sexual health” (p. 232) is essential (Lewis, 2004). Specifically, for the purposes of this research, cultural philosophies, able-ism, and patriarchy will be examined closely for their impact on sexual development and education in the early years.

Culture is a significant component of the macrosystem, as it impacts how sexuality is perceived. For example, in some cultures (e.g., African-America, Latino, Native-American, and others), assertive behaviour is seen as disrespectful and therefore teaching dissent may directly challenge cultural practices (Kenny et al., 2008). Moreover, in some cultures, females are often expected to be gentle, whereas males are socialized to be aggressive (Ogunfowokan & Fajemilehin, 2012). Many cultures view males as sexual experts, suggesting that they are innately knowledgeable and therefore may not require sexuality education (Walker & Milton, 2006). There are additional factors that may impact some African girls’ sexual development, including the frequency of female genital mutilation, child marriage, and breast flattening (Ogunfowokan &
Fajemilehin, 2012). These differences in gender roles across cultures can impact how sexuality education is provided to, and perceived by, children.

Whereas policy makers are responsible for determining curriculum, how educators view their students may be reflective of these generalizations and assumptions, indicating the need for a cultural shift at the macrolevel (Froyum, 2010). In valuing cultural diversity and family choice, many sexuality education programs offer families an option to withdraw their child during sexuality education, though few parents accept this offer (~2%) (Downing et al., 2011; Sabia, 2006). An example was provided by Haggis and Mulholland (2014) of how the choice to opt-out may be reflective of cultural expectations: a Muslim family opted not to allow their child to partake in learning about premarital sex, as it directly opposes their belief system. This is one example of the challenge of providing fully inclusive sexuality education: although a sex-positive approach could enhance sexual agency, if Muslim children whose culture opposes these views were included, it could serve to reinforce hegemony, disregarding or devaluing their unique beliefs and practices. Therefore, it is essential to value and respect diversity in the adoption of inclusive sexuality education.

The macrosystem also encompasses stigma which may impact how healthcare and education is accessed (Harper et al., 2014). For example, the portrayal of sexuality of individuals with disabilities, “while useful in demonstrating the need for socio-sexuality education for [children with autism], [it] has also managed to perpetuate the stigma of sexuality as a problem in need of management” (Gougeon, 2010, p. 355). As stated by Trace (2014), “I realized that denying my identity and not calling myself disabled was an ableist manifestation. I had bought into the idea that able-bodied people were more
valuable than those who are disabled” (p. 98). An example of able-ism persisting in sexuality is shared by Philander and Swartz (2006) who shared the experience of a participant indicating that “it gives a mental boost to a disabled girl to have a partner who is not disabled” (p. 112). It is also evident that even when care providers and friends accept individuals with physical disabilities, they may not be as eager to engage in a romantic relationship, compounding the socially held view of individuals with disabilities as asexual (Murphy & Young, 2005; Parchomiuk, 2012). The adoption of person-centered practices enables all individuals to make informed decisions about their sexual lives and health care, shifting the doctor/patient, able/disabled binary to a collaborative partnership (Dune, 2012).

The exclusion of children with disabilities from sexuality education may be due to beliefs that sexuality education is “irrelevant”, as individuals with developmental disabilities are perceived to be asexual or “eternal children”, in need of protection (Abramson et al., 2013; Anderson & Kitchin, 2000; Povilaitienë & Radzevicienë, 2013; Sullivan et al., 2013, p. 3457). For example, in a study by McConkey and Leavey (2013), respondents believed that individuals with intellectual disabilities should not have the same access to sexuality as their peers for reasons including a perceived inability to provide consent, vulnerability to abuse, inability to raise children, and inability to maintain relationships with others. As such, supporting the sexual development of individuals with developmental disabilities should extend beyond educating only the individual, calling for a change in community perspective, debunking stereotypes, challenging attitudes, and focusing on how to proactively support healthy sexual development and agency (Bowman et al., 2010; McConkey & Leavey, 2013).
Individuals who identify within a sexual minority or identify as trans may likewise experience stigma based on their expressions of sexual and/or gender identity, impacting their healthy sexual development (Operario, Yang, Reisner, Iwamoto, & Nemoto, 2014). Furthermore, as previously mentioned, mothers often fear the stigma associated with being in a partnership with a sexual offender, reinforcing the heteronormative idea that females should be able to be able to both “protect their children...[and] manage their adult relationships” (McLaren, 2013, p. 445). In examining patriarchy as a “structure of social control” (McCarty-Caplan, 2013, p. 250), it is clear that certain gendered expectations exist in order to maintain the binary of male/female, or, more specifically, because of “social, institutional, and influential rules” (Gedro & Mizzi, 2014, p. 451), males are valued as dominant and females as oppressed within the gender hierarchy (Dykstra, 2005; Gedro & Mizzi, 2014; McCarty-Caplan, 2013). Patriarchy persists in sexuality education, as males are seen as immature and irresponsible, whereas females are seen as innocent and in need of protection, and therefore “must act as gatekeepers to both their own and boys’ sexuality” (Buck & Parrotta, 2014; Preston, 2013, p. 20). Embracing a feminist lens could challenge the “naturalness” of patriarchy, which serves to maintain heteronormativity, continuing the social structure as male and female as opposite of, and in need of each other (Foucault, 1978; McCarty-Caplan, 2013; Payne & Smith, 2014).

Challenging heteronormativity in providing sexuality education is essential, as much of sexuality education is based on partnered, male/female expressions of sexuality, often ignoring other sexual identities, which “legitimates heterosexuality as that default position” (Surtees, 2008, p. 10). However, because of this norming, sexual identities
which challenge heteronormativity continue to be seen as “unnatural” (Cheshire, 2013). There are some concerns that parents may not be comfortable with their students being taught sexual identity at school, because of their own comfort level, and because they feel that it is not developmentally appropriate (Flores, 2014). However, “during early youth, children are forming cultural identities, friendships, developing opinions, and appreciating others…developing a sense of fairness and friendships, developing opinions, and appreciating others” (Flores, 2014, p. 117). These skills will prepare children to be members of an inclusive, diverse society, and moreover, “it is the ethical thing to do” (Flores, 2014, p. 117).

Kenny et al. (2008) shared that healthy sexuality should be the context of teaching sexual abuse to children. The authors liken teaching sexual abuse to teaching traffic and fire safety, that is teaching safety within an understanding of the possibility of danger. According to Hingsburger (1995), “sex is good and if it isn’t good it isn’t sex” (p. 73). By acknowledging the role of pleasure in sexuality, children may be able to discern abuse from care, and safe from unsafe. Hingsburger (1995) also describes sex as mutual, pleasurable, and consensual, and explains that if these three components are not met, the encounter can be considered abusive in nature. Both contact (i.e., touch or penetrative) and non-contact (i.e., looking, harassment, innuendo) forms of abuse, as described by Brown and Turk (1994), should be included in programming in order to support learning about healthy sexuality.

Whereas there are typically not laws to outline how sexuality education will be provided and by whom, the responsibility for determining this falls to those in a position of power, which may be impacted by the individual’s values and beliefs, as well as by
budget, time, and resource limitations of programs (Paranal et al., 2012; Saxe & Flanagan, 2013). Family resource centre staff are impacted by shifting laws, as they have a duty to report suspected abuse under Nova Scotia law, as previously mentioned. On a community level, legal shifts impact the consequences of sexual behaviours, the age of protection, and the determination of capacity of consent to sexual activity.

**Chronosystem**

The chronosystem is an overarching recognition that “time changes everything”; time can impact the child both a cultural level (e.g., as philosophies, laws, and knowledge change) and at an individual level (e.g., as the child ages). Recognizing that the current research is a snapshot in time, and that best practice is responsive to time, the chronosystem is an essential aspect of understanding sexuality education. As stated by Robinson and Davies (2008),

“It is no longer appropriate or possible to teach sexuality within the same hegemonic scientific and moralising discourses that have operated in the past 50 years. Changing technologies, children’s access to information on the internet, greater awareness of nonheterosexual identities, relationships and families, and significant shifts in meanings and experiences of childhood, require more open and complex discussions around sexuality with children if they are to become competent, informed, and agentic citizens” (p. 223).

Whereas the chronosystem is an overarching system, its shift impacts legal developments, value and attitudinal shifts, and a change in perspective and development. For example, the development of technology has allowed for privatized access of information (e.g., looking up information online, viewing pornography for free, etc.).
Time has also impacted some cultures with regards to legalization of same sex marriage, trans rights, decriminalization of sex work, age of protection, and other shifts in sexuality and sexuality education.

One example of the effects of time on sexuality education is in examining the sexuality of individuals with disabilities. Historically, the sexuality of individuals with disabilities was controlled through eugenics, “the systematic control of breeding” (Job, 2004; O’Brien, 2011, p. 347). Specifically, individuals with disabilities were deemed unfit for procreation and were therefore sterilized or institutionalized (O’Brien, 2011). The concurrent creation of the intelligence test proved to delineate “normal” from “abnormal”, and gave power to individuals who did not have a disability over those they deemed disabled, giving them the right to “make judgments about the nature and personal meaning of the ‘minority condition’” (Job, 2004; O’Brien, 2011, p. 348; O’Brien & Bundy, 2009). Alberta and British Columbia were the only Canadian territories to enact legislation prompted negative eugenics, and Alberta practiced negative eugenics beginning in 1929, impacting 2834 individuals (Grekul, Krahn, & Odynak, 2004). In 1972, the act was repealed, for reasons including changes in leadership, changes in religious practices, “the medical, mental health and social work professions were gaining credibility” (Grekul et al., 2004, p. 379). As stated by Gougeon (2010), “it is a matter of societal barriers, not simply personal impairment, that prevent access to the individuals’ full sexuality rights” (p. 352).

The chronosystem also is supported at an individual level, as children’s age impacts their sexuality and the education they may receive as a result. Children’s sexuality is often ignored in response to “childhood innocence, a socially constructed
concept… a critical and powerful tool that operates to maintain adult-child binary power relationships” (Robinson & Davies, 2008, p. 223). However, sexuality education programs often begin during preadolescence, as a direct response to a specific milestone: puberty. There is indication in the research that sexuality education should be “developmentally appropriate”, taking into consideration a child’s age and developmental level. However, with unclear milestones or developmental trajectories, “developmentally appropriate” becomes a socially constructed notion of a child’s readiness, based on an adult’s comfort and assertion (Robinson & Davies, 2008). It is important to consider the impact that time has on sexual development and sexuality education on both an individual and cultural level.

Summary

It is clear that children’s sexuality and the provision of sexuality education is impacted by many components, including individual factors, characteristics of the individuals they are in close contact with, their communities and programs accessed, the cultural practices and beliefs that guide them, and time, both at an individual and cultural level, as recognized within Bronfenbrenner’s ecological systems theory. Recognizing that children’s sexual development impacts-and is impacted by- elements within their ecological systems, sexuality education must be responsive and inclusive.
CHAPTER IV

Method

This study intended to identify how family resource centres in Nova Scotia are supporting families in the provision of inclusive sexuality education in the early years. A needs assessment survey was used to determine how children’s healthy sexual development is addressed by family resource centre staff, and how these staff are supported within this particular aspect of service delivery. Family resource centre staff were identified as a key population to engage, as their knowledge and experience about child development, family centered practice, and community engagement could lead to identifying current practices, existing gaps, and potential opportunities for the provision of inclusive sexuality education in the early years. Responses were analyzed for commonalities and disparities, drawing implications for practice and future research.

Participants

Using criterion sampling, all participants were employed by a Nova Scotia family resource centre at the time of the survey. Family resource centres in Nova Scotia serve families beginning with prenatal care, offering a variety of programs, both onsite and in an outreach capacity, such as parent-and-tot groups, parenting groups, transition to school support, and courses such as First-Aid/CPR and infant massage (Maggie’s Place, n.d.). Additionally, family resource centre staff have a duty to report suspected abuse under Nova Scotia law;

“in the course of that person’s professional or official duties, has reasonable grounds to suspect that a child is or may be suffering or may have suffered abuse
shall forthwith report the suspicion and the information upon which it is based to an agency” (Children and Family Services Act, SNS 1990, c5, s24).

A large sample size was desired in order to obtain multiple perspectives, reflecting the diversity of Nova Scotia. Specifically, a large sample size would allow for representation of rural and urban communities, as well as communities who identify as Acadian, immigrant, aboriginal, African Nova Scotian, and military. Inclusion criteria for respondents were identified in the Free and Informed Consent Form (Appendix D), and included that they be of the age of consent (i.e., at least nineteen years of age), be employed by a family resource centre, and that, within their capacity at the family resource centre, they support families with children in the early years (i.e., birth to school entry).

Measures

A review of the literature combined with professional experience led the researcher to develop a nine question electronic survey (Appendix F), intended to provide insight into how young children’s sexual development and sexuality education is addressed by family resource centre staff in their roles. Questions followed a sex-positive approach, highlighting education, and promoting diversity in approaches to, beliefs about, and expressions of, sexuality, reflecting “rights over risks” and limiting reference to sexual abuse, shame, or stigma (Lamb, Lustig, & Graling, 2012; Williams et al., 2013). After developing the survey, feedback was obtained by colleagues of the researcher, representing the following fields: early childhood education, social work, applied behavior analysis, and early childhood developmental intervention. Questions were adjusted to reflect the comments of these first reviewers, allowing for more accurate
responses by respondents. Respondents completed an online computer-assisted self-interview, hosted by www.LimeSurvey.com. Initial questions asked for demographic information in order to correlate responses with participant characteristics. Further questions sought information about professional development opportunities and professional support available for staff, information about the support and resources families are seeking, and how family resource centre staff are able to meet the needs of all families and children in their communities with regards to healthy sexual development in the early years, with a particular emphasis on inclusive practices.

Procedures

Prior to beginning the research, ethical approval was obtained from the Department of Child and Youth Studies and subsequently the Mount Saint Vincent University Research Ethics Board. A list of contact information for all Nova Scotia family resource centres was obtained online via the Nova Scotia Council for the Family website, which listed 38 family resource centres. Following a brief phone call with the Scotia Court Family Centre, the centre was not included with the study as they were not a family resource centre, but were a place for families to access legal support and counselling through legal aid. Executive directors from the remaining 37 family resource centres (Appendix A) were contacted via E-mail (Appendix B), asking them to distribute an Invitation to Participate (Appendix C) and Informed Consent Form for Online Survey (Appendix D) to all of their staff. Also included in the Invitation to Participate E-Mail was the link to complete the online computer-assisted self-interview (Appendix E), which immediately linked participants to the Informed Consent Form for Online Survey (Appendix D). Participants were not able to move forward with the survey if they did not consent to
participate in the research. Participants then completed the survey questions and submitted their responses by clicking “submit”. As survey responses were anonymous, respondents were reminded before clicking “submit” that their answers could not be revoked after submission. Initial invitations to participate indicated that the survey would be available for two weeks; however, in order to enhance return rates, the decision was made to extend the date for a third week. Follow up E-Mails were sent to all executive directors after the end of the first and second weeks asking for them to re-distribute information to all of their staff in order to maximize response rates.

Due to the potential psychological risks presented with the topic of children’s sexual abuse, a list of available community supports was provided with the Informed Consent Form for Online Survey (Appendix D), in order to ensure that, should invitees experience triggers, they could access supports independently and confidentially. Additionally, participants were informed in each the Invitation to Participate (Appendix C) and the Informed Consent Form for Online Survey (Appendix D) that their responses would be anonymous and that they could withdraw from the research at any time.

Data Analysis

Due to limited data (n=5), responses were calculated numerically. The answers were applied to the ecological systems theory to determine how children are being supported individually and across the multiple, integrated levels of their ecosystem? Additional questions when reviewing the data included:

1. How are family resource centre staff delivering sexuality education?

2. What educational opportunities exist (both pre-services and professional development) to support family resource centre staff in the provision of family-
centered sexuality education in the early years? What opportunities would be helpful?

3. How is the diversity of all families and children reflected in program delivery and materials?

Ethical Considerations

Confidentiality and Informed Consent. All data was kept anonymous to the researcher by using the “anonymized responses” feature offered by LimeSurvey. This ensured that all data was confidential and responses would not impact the individual or centre with which they are employed. An Informed Consent Form for Online Survey (Appendix D) was included as the first question of the survey and interested respondents were not able to access the remainder of the survey without first consenting to participate. In both the Invitation to Participate (Appendix C) and the Informed Consent Form for Online Survey (Appendix D), participants were reminded of their right to withdraw from the study at any time, and of their right to skip any question(s) should they choose to.

Issues of Harm. Due to sensitivity inherent in the topic of children’s sexuality and sexual abuse, some psychological harm was anticipated. Although no questions specifically asked for personal information related to sexual abuse, the possibility of triggers existed at all stages of the study. Anticipating this, a list of available community supports was included in the Informed Consent Form for Online Survey (Appendix D), allowing individuals to access support in such a way that would maintain privacy. Participants were reminded at multiple times (i.e., in the Invitation to Participate (Appendix C) and the Informed Consent Form for Online Survey (Appendix D)) that they could skip any questions in the survey and could withdraw from the research at any time.
without penalty. The list of available community supports was developed in collaboration with a social worker in the field of sexualized violence in order to ensure that suggested supports were appropriate and reasonable.

**Limitations**

The delimitations presented in this study are that only staff at Nova Scotia family resource centres were able to participate. There is certainly merit to widening the geographic scope of response, gaining multiple perspectives on how all families are supported with their children’s healthy sexual development in the early years. Additionally, families were not contacted directly, rather the information was obtained from family resource centres, which may not be an accurate representation about what families have, want, and need regarding their children’s healthy sexual development. Furthermore, family resource centre staff could only provide perspective on families who access the family resource centre, indicating that there are families who are not represented in the present research. However, family resource centres were selected because it was believed that they could best represent multiple perspectives from multiple families, and because the information gleaned from family resource centres may enhance family-centered practice in order to build capacity within families. Much of the available literature centers on teachers within an educational capacity, because of the roles of family resource centre staff in providing both family- and child- education, it is felt that the knowledge of the roles, opportunities, and impacts of teachers providing sexuality education will reflect the experiences of family resource centre staffs in a similar capacity. Additional delimitations included language limitations, as the survey was only distributed in English, which may exclude interested individuals from participating,
which could be especially impactful when trying to assess perspectives of family resource centre staff serving aboriginal, immigrant, and Acadian families.

Limitations of the current study included a small sample size (n=5), impacting the generalizability of the information, especially whereas all respondents represented rural communities. Each response gave perspective into how family resource centre staff are supporting family-centered, inclusive sexuality education in the early years, though certainly more responses would meaningfully impact generalizability.

**Dissemination**

A summary of the results of the study was E-mailed to all executive directors of the 37 family resource centres in Nova Scotia. Additionally, in the invitation to participate, individuals were welcomed to contact the researcher to obtain results. Results were also posted online, hosted by Mount Saint Vincent University (E-commons; [http://dc.msvu.ca:8080/xmlui/handle/10587/602](http://dc.msvu.ca:8080/xmlui/handle/10587/602)).
CHAPTER V

Results

The purpose of this study was to determine how family resource centres are supporting families in their provision of inclusive sexuality education to their young children. The limited response rate (n=5) makes it impossible to these results; however, the results of the respondents reflect their individual perspective, experience and knowledge about how the family resource centre that they each work at supports families in their provision of inclusive sexuality education to young children. The five survey participants had varied responses to topics exploring pre-service training, professional development, direct support for children, supporting families as sexuality educators, and the provision of extra support where warranted.

Demographics

There were five respondents who consented to participate in the present study (n=5), all of whom self-identified as female, and their ages ranged within 19-59 years. Each respondent had a different level of education: high school, college, diploma in Early Childhood Education, Bachelor Degree, and a Bachelor of Social Work. One individual identified as working in Early Childhood Development and Education, three as working in Family Support, and one who identified “other”, specifying that each option presented (i.e., Early Childhood Development and Education, Family Support, Administrative, and Management) applied to her work. There was a range of length of employment at the family resource centre (i.e., one for 3-5 years, one for 5-10 years, two for 11-15 years, and one for 16-20 years). All five respondents described the community they serve as rural, and one also included that they support Military Families.
Pre-Service Delivery

Four respondents identified that they had prior training in child development, whereas two had training specific to children’s sexual development. Three respondents had pre-service training related to child abuse, and two had training specific to children’s sexual abuse. None of the respondents identified having received training in gender diversity or sexual identity, though at least one respondent identified having received preservice training in each other area questioned. Three respondents identified that they had received no training in any areas questioned that related to children’s sexual development, and one had no training related to children’s overall development.

Professional Development

Since working at the family resource centre, respondents had participated in professional development (PD) opportunities pertaining to the following topics: children’s healthy sexual development (n= 3), child sexual abuse (n= 3), gender diversity in sexuality development and education (n= 2), cultural diversity in sexuality development and education (n= 2), ability diversity (e.g., intellectual disability, physical disability, autism spectrum disorder, vision loss, hearing loss) in sexuality development and education (n= 2), sexual identity (e.g., LGBTQ) diversity in sexuality development and education (n= 2), family composition diversity sexuality development and education (n= 2), language diversity in sexuality development and education (n= 2), racial diversity in sexuality development and education (n= 1), religious diversity in sexuality development and education (n= 1), and two respondents had not participated in PD related to any of the aforementioned topics.
Within the last five years, two respondents had not attended any PD opportunities related to children’s sexual development, two individuals had attended one opportunity, and one individual had attended two. Barriers identified for obtaining PD opportunities about children’s sexual development included not having opportunities available (n=2), financial restraints (n=1), and not enough notice (n=1), whereas one respondent identified not having any barriers presented. All five respondents reported wanting PD related to children’s sexual development. The following PD opportunities were identified as “would be helpful” in guiding families in supporting children’s developing sexuality; ability diversity (e.g., intellectual disability, physical disability, autism spectrum disorder, vision loss, hearing loss) in sexuality development and education (n= 3), sexual identity (e.g., LGBTQ) diversity in sexuality development and education (n= 3), child Sexual Abuse (n= 3), gender diversity in sexuality development and education (n= 3), children’s healthy sexual development (n= 2), cultural diversity in sexuality development and education (n= 2), family composition diversity in sexuality development and education (n= 2), religious diversity in sexuality development and education (n= 1), language diversity in sexuality development and education (n= 1), and racial diversity in sexuality development and education (n= 1).

**Supporting Children’s Healthy Sexual Development**

Four respondents provided examples of individual support offered, which included specific responses such as “hand outs, dvds, kits, and almost instant acess [sic] to the sexual health educator”, “use appropriate and correct language for body parts, being respectful of children and their desire to be held, hugged, etc.”, “monitoring changes in behavior of child and seeking team support when concerns arise”, “speaking
with parents regarding any reports that may need to be made”, “referrals to counseling and other supports if necessary”, “home visitors will listen to their clients concerns and find answers to questions. Coordinators will give out information as requested during programs”. Four respondents indicated that anatomically correct and/or gender specific dolls were available to children to support sexuality education in the early years. Three respondents identified books they offer directly to young children to support their healthy sexual development. No movies or DVDs were used by respondents to support children’s healthy sexual development. Two respondents included comments pertaining to how they support children’s sexual development directly, one indicating that she had “not worked with young children regarding this subject matter”, and the other sharing that, “because we have instant access to the sexual health center i [sic] haven't really paid attention to what we have in the center. Every resource center should have a Sexual health center in their facility”

**Supporting Families**

Individual support offered by respondents to families of young children in order to build capacity in supporting children’s healthy sexual development included counselling and support, referrals to the sexual health centre, provision of education and information. Respondents felt that gender was always reflected (n=5) in this type of support, and the following were also reflected: age (n=4), family composition (n=4), culture (n=2), ability (n=1), sexual identity (n=1), and language (n=1). Three respondents provided examples of workshops offered to families of young children to build their capacity in supporting young children’s healthy sexual development, including “I incorporate Sex ed for parents into each program I facilitate”, and “child development
programs for parents with guest speakers from victims services, transition house and sexual health center”. Participants felt that each area of diversity was reflected, though some more strongly than others (e.g., n=3 for each gender, family composition, and age).

Four respondents provided examples of brochures and pamphlets offered to families with young children, including titles such as Talk Sex (Nova Scotia Department of Health) (n=2), Private Zone - A Guide for Children to Prevent Sexual Molestation (Frances S. Dayee), Keeping Our Kids Safe (RespectEd), and The Stork Didn't Bring You (Newfoundland Department of Health). One respondent indicated that their centre had “kits” that parents could access which included books and DVDs. Between each of these four respondents, each area of diversity was represented once in describing how diversity was reflected in the brochures and materials provided. Four respondents identified books that they offer to families to support children’s sexual development, and responses indicated that gender (n=4) and age (n=4) were most represented, and culture (n=1) and religion (n=1) were least represented. One respondent expanded on the question of family support provided, indicating that, “the Sex Made Simple kit is available at our Family Resource Centre to participants. When a parent has questions we will often bring the kit to them”. Table 1 shows responses reflecting the perceptions of staff regarding how often families are seeking information about their children’s sexual development in the early years.
Respondents perceived families to be asking for information across all ages, and most frequently for their three to six year old children. Specifically, respondents’ perceptions of how often families are seeking information about their infant’s sexual development included never (n=2), rarely (n=2), and sometimes, (n=1), for children between 12 and 24 months as rarely (n=2) or sometimes (n=3), and that families of two year old children are seeking information rarely (n=1), sometimes (n=2), or usually (n=2). Additionally, respondents believed that families were asking for information to support their children at three, four, five, and six years at the same frequencies (i.e., sometimes (n=3), usually (n=2)). In terms of how often respondents included children’s sexual development in their programs, responses indicated a full spectrum (i.e., n=1 for each never, rarely, sometimes, usually, and always). Three respondents indicated that they “usually” wait for families to ask about sexual development, whereas one responded with “never” and one with “rarely”. Four respondents indicated that they “never” avoid the topic of children’s sexual development, and one reported that they “rarely” avoid the topic. Four respondents indicated that centre policies did not impact their choice of whether to include children’s sexual development programming; responding with comments including, “our programs are participant driven, a program would be offered.

Table 1: Respondent perceptions of frequency of families beginning to seek information about healthy sexuality for their young children by age.

<table>
<thead>
<tr>
<th>Age</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>n= 2</td>
<td>n= 2</td>
<td>n= 1</td>
<td>n= 0</td>
</tr>
<tr>
<td>12-24 Months</td>
<td>n= 0</td>
<td>n= 2</td>
<td>n= 3</td>
<td>n= 0</td>
</tr>
<tr>
<td>2 years</td>
<td>n= 0</td>
<td>n= 1</td>
<td>n= 2</td>
<td>n= 2</td>
</tr>
<tr>
<td>3 years</td>
<td>n= 0</td>
<td>n= 0</td>
<td>n= 3</td>
<td>n= 2</td>
</tr>
<tr>
<td>4 years</td>
<td>n= 0</td>
<td>n= 0</td>
<td>n= 3</td>
<td>n= 2</td>
</tr>
<tr>
<td>5 years</td>
<td>n= 0</td>
<td>n= 0</td>
<td>n= 3</td>
<td>n= 2</td>
</tr>
<tr>
<td>6 years</td>
<td>n= 0</td>
<td>n= 0</td>
<td>n= 3</td>
<td>n= 2</td>
</tr>
</tbody>
</table>
based on parents interest”, “It would depend on a program facilitator and whether or not they include information or bring in guest speakers, this topic is always encouraged but not part of a policy”, and “If participants requested a program around this topic we would make it available”

Respondents indicated the following reasons for why they have ever struggled with the topic of children’s sexual development; inadequate knowledge (n=1), inadequate materials to support families (n=1), outside of scope of practice (n=1), not wanting to offend families (n=1), a perception that families do not ask for this information (n=2), not wanting to give families inadequate information (n=2). None of the respondents felt that the children they worked with were too young, nor did any respondents feel embarrassed or unsupported, and none felt that they had to prioritize other topics.

Respondents shared their comfort levels with providing support for families on topics related to children’s sexual development and education, and, based on their experiences, their perceptions of how frequently families are seeking information on the same topics (see Table 2).

<table>
<thead>
<tr>
<th>Table 2: Staff Perceptions of Family Curiosity, and Staff Comfort</th>
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</thead>
<tbody>
<tr>
<td><strong>Privacy</strong></td>
</tr>
<tr>
<td>Often (n= 1)</td>
</tr>
<tr>
<td>Sometimes (n= 1)</td>
</tr>
<tr>
<td>Rarely (n= 2)</td>
</tr>
<tr>
<td>Never (n= 1)</td>
</tr>
<tr>
<td>Consent</td>
</tr>
<tr>
<td>Often (n= 1)</td>
</tr>
<tr>
<td>Sometimes (n= 0)</td>
</tr>
<tr>
<td>Rarely (n= 3)</td>
</tr>
<tr>
<td>Never (n= 1)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Category</td>
</tr>
<tr>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Self-Pleasure, Masturbation</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Sexual Identity (e.g., LGBTQ, two-spirit)</td>
</tr>
<tr>
<td>Relationships</td>
</tr>
<tr>
<td>Procreation (where babies come from)</td>
</tr>
<tr>
<td>Child birth</td>
</tr>
<tr>
<td>Sexual intercourse</td>
</tr>
<tr>
<td>Sexual acts</td>
</tr>
<tr>
<td>Naming body parts</td>
</tr>
<tr>
<td>Topic</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Protective methods (e.g., condoms, birth control)</td>
</tr>
<tr>
<td>Media’s impact on sexuality</td>
</tr>
<tr>
<td>Hypersexualization (e.g., having sexuality imposed-often by media)</td>
</tr>
<tr>
<td>Sexually Transmitted Infections (STIs)</td>
</tr>
<tr>
<td>Sexual abuse prevention</td>
</tr>
<tr>
<td>Concerns about their child having experienced sexual abuse</td>
</tr>
<tr>
<td>Sexual behaviours demonstrated by their children</td>
</tr>
</tbody>
</table>

Respondents were asked questions about a series of topics that may be included in sexuality education programming, and were asked to reflect on their own comfort level with the topic, and to reflect on their experience with families in how often families are seeking information on the same topic. Comfort level was ranked from 1 to 5, with 1
being “very uncomfortable” and 5 being “very comfortable”. Calculating average “comfort levels” of the respondents indicated that, for the five respondents, the most comfortable topics were protective methods (e.g., condoms, birth control) ($\bar{x} = 4.8$), naming body parts ($\bar{x} = 4.6$), and child birth ($\bar{x} = 4.6$), and the least comfortable topics were sexual abuse prevention ($\bar{x} = 2.6$) and sexual acts ($\bar{x} = 2.6$). The average comfort levels of respondents were as follows: sexual intercourse ($\bar{x} = 4.4$), procreation (where babies come from) ($\bar{x} = 4.4$), media’s impact on sexuality ($\bar{x} = 4.2$), relationships ($\bar{x} = 4.2$), sexually transmitted infections (STI) ($\bar{x} = 4$), sexual behaviours demonstrated by their children ($\bar{x} = 3.6$), hypersexualization (e.g., having sexuality imposed-often by media) ($\bar{x} = 3.6$), gender ($\bar{x} = 3.6$), self-pleasure ($\bar{x} = 3.6$), masturbation ($\bar{x} = 3.6$), privacy ($\bar{x} = 3.6$), concerns about their child having experienced sexual abuse ($\bar{x} = 3.4$), consent ($\bar{x} = 3.4$), and sexual identity (e.g., LGBTQ, two-spirit) ($\bar{x} = 3.2$).

In order to understand the perceptions of staff with regards to how often families are seeking information on various topics related to children’s sexual development, respondents were asked to reflect on their experiences, and rate each topic as either often, sometimes, rarely, or never. Results were analyzed numerically with each rating scored as follows: never=1, rarely=2, sometimes=3, and often=4 and scores were added to better understand the staff perceptions of the frequency with which families are seeking support on the listed topics. According to the five respondents, the following topics were most often requested: relationships (n=17), protective methods (e.g., condoms, birth control) (n=15), and naming body parts (n=15), and the least frequently sought after were sexual acts (n=10) and sexual identity (e.g., LGBTQ, two-spirit) (n=10). Other topics included child birth (n=14), procreation (where babies from from) (n=14),
hypersexualization (e.g., having sexuality imposed—often by media) (n=13), gender (n=13), self-pleasure (n=13), sexual behaviours demonstrated by their children (n=12), sexual abuse prevention (n=12), media’s impact on sexuality (n=12), privacy (n=12), concerns about their child having experienced sexual abuse (n=11), sexually transmitted infections (STIs) (n=11), and consent (n=11).

In order to better understand how respondent pre-service training and professional development impacted their comfort levels with the various topics, each respondent’s “comfort scores” were added, as were their responses indicating how many elements of training they had participated in (table 3). Respondent “A” had attended no pre-service training opportunities nor professional development opportunities and had a total “comfort score” of 73, respondent “B” had attended 3 pre-service training opportunities and 4 professional development opportunities and had a total “comfort score” of 58, respondent “C” had attended no pre-service training opportunities and 6 professional development opportunities and had a total “comfort score” of 84, respondent “D” had attended 11 pre-service training opportunities and 10 professional development opportunities and had a total “comfort score” of 60, and respondent “E” had attended no pre-service training opportunities nor professional development opportunities and had a total “comfort score” of 67.

Table 3: Education and Comfort Level: Pre-service training and professional development participation and participant comfort scores

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Pre-service Training Opportunities</th>
<th>Professional Development Opportunities</th>
<th>Total “Comfort Score”</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0</td>
<td>0</td>
<td>73</td>
</tr>
<tr>
<td>B</td>
<td>3</td>
<td>4</td>
<td>58</td>
</tr>
<tr>
<td>C</td>
<td>0</td>
<td>6</td>
<td>84</td>
</tr>
<tr>
<td>D</td>
<td>11</td>
<td>10</td>
<td>60</td>
</tr>
<tr>
<td>E</td>
<td>0</td>
<td>0</td>
<td>67</td>
</tr>
</tbody>
</table>
**Extra Support**

The following services were reported by the five respondents as supports to whom families have been referred for additional support with the topic of children’s sexual development and sexuality education; Developmental Interventionist/Early Childhood Interventionist (n=3), Sexual Health Centre (n=3), Family Physician (n=2), Youth Project (n=2), Mental Health Agency (n=2), Paediatrician (n=1), Elementary school personnel (either during primary transition or through consultation) (n=1), Public Health Agency (n=1), and one respondent had never referred families for outside support. None of the respondents indicated any challenges in accessing the aforementioned supports. However, the following community partners were not identified by respondents as supports to whom families have been referred (n=0): APSEA (Atlantic Province Special Education Authority), Early Childhood Educator, EIBI (Early Intensive Behavioural Intervention Program), Occupational Therapist, Psychologist. One challenge that was reported by a respondent in supporting children and their families in regards to children’s healthy sexual development was “having resources that are easy to understand (literacy level) for parents”.

CHAPTER VI

Discussion

Results reflected the value in supporting family-professional collaboration in the provision of sexuality education in the early years. It is important to review and interpret the results with caution, as the low response rate does not allow for generalization, and the five responses may not fully reflect the reality of what family resource centre staff are doing to support children’s sexual development. Respondents felt that families are seeking information and support about their children’s developing sexuality from their family resource centres, and that there is a need to support the education of family resource centre staff to ensure best service delivery that is inclusive, developmentally appropriate, and family-centered. Parental communication can impact a child's behaviours and decision making, though children often rate their parents’ efforts at sexuality education as ineffective, reflecting the need to increase parental capacity (Cox et al., 2010; El-Shaieb & Wurtele, 2009). Results of the present study mostly reflected the individual, microsystem, and mesosystem of the ecological systems theory (EST). However, in keeping with the EST, it is essential to consider that each of those factors impact and are impacted by the other systems (i.e., exosystem, macrosystem, chronosystem) as previously explored. The mesosystem describes an interaction between two systems, which is clear in the present study when reviewing how family-resource centre staff are interacting with families, children, and other professionals in the field.

Family Resource Centre Staff Education

Results indicated that pre-service training related to children’s sexual development was limited (n=2), as was professional development (PD) while in the field,
as two respondents had attended no opportunities in the past five years, whereas two respondents had attended one training, and one respondent had attended two. This parallels research indicating that pre-service training and professional development opportunities are both lacking and necessary in order to support sexuality education of children (Dune, 2012; Lai, 2006; Mahoney & Poling, 2011; Payne & Smith, 2014). All five respondents in the present study indicated that they would like PD on children’s sexual development. Results indicated that, specifically, the most wanted (n=3) PD topics included sexual identity diversity, gender diversity, child sexual abuse, ability diversity, whereas the fewest sought after topics pertained to religious diversity, language diversity, and racial diversity (all n=1). These responses reflected what individuals had received training in during their employment, as the topics with the most training included child sexual abuse and child sexual development (n=3), whereas the least obtained topics included religious diversity and racial diversity (n=1). Bowden et al. (2003) found that teachers’ beliefs impact their service delivery: “even an effective program cannot impact children’s sexual abuse prevention if individuals are unwilling to engage in and complete the training” (Rheingold et al., 2012, p. 424).

Surprisingly, survey respondents with no training opportunities appeared more comfortable with topics respondents perceived families to be seeking information about most often. This may be ascribed to the Dunning-Kruger effect, wherein individuals “don’t know what they don’t know” (Huang, 2013, p. 414). According to the Dunning-Kruger effect, metacognition impacts the relationship between perceived and actual performance, indicating that those who are not aware of what they do not know may overestimate their abilities and potential (Huang, 2013; Williams, Dunning, Kruger, &
Smith, 2013). In this context, it may be that respondents who have not yet thought critically about their role as sexuality educators may over-estimate their ability to provide comprehensive sexuality education. Huang (2013) writes of the difference between the “known unknowns” and the “unknown unknowns”, clarifying that more competent individuals are aware of their own knowledge gaps, which may be reflective of respondents who had engaged in more education opportunities (both pre-service and professional development) who rated their comfort with various topics as lower than their peers with little or no training. Existing literature suggests that curriculum implementation should include a training component for those who will be disseminating the information, in order to ensure that they are comfortable, capable, and competent in providing inclusive, respectful education (McCarty-Caplan, 2013; Preston, 2013). All respondents did indicate wanting PD opportunities, suggesting that there is value in incorporating children’s sexual development into both pre-service training and PD while in the field.

**Healthy Sexual Development**

It is important to value sexuality as “a normative and positive aspect of child development” (Dewinter et al., 2013, p. 3468). Though four respondents had pre-service training about child development, only two had training specific to children’s sexual development. Since working at a family resource centre, three respondents had attended PD on the topic (two having attended one opportunity, and one having attended two). Two respondents indicated that they would find PD opportunities on children’s healthy sexuality development helpful. As highlighted in Table 1, respondents felt that families were most often seeking information about healthy sexuality for their young children.
between three and six years of age, though some asked earlier. None of the respondents believed that the children they worked with were too young, which opposes the notion of vulnerability presented in the literature, that some believe children are inherently vulnerable and in need of protection. This is important to note as sexuality education begins at birth and is influenced throughout the child’s lifespan by school, society, and family (Kakavoulis, 1998; Lai, 2006). As stated by Kakavoulis (1998), “sex education of the child is more important than sex education of the adolescent, as the second one is, to a great extent, part of the first” (p. 64).

According to the literature, though mothers typically began sexuality education earlier than fathers did, many mothers waited for their children to begin the conversation on sexuality, whereas others waited for specific developmental milestones (Angera et al., 2008; Cox et al., 2010). Similarly, in the present research, three respondents “usually” wait for families to ask about sexual development, though one “never does”, one respondent “rarely” avoids the topic, and four “never” do. One respondent added, “I incorporate Sex ed for parents into each program I facilitate. I feel its very important and is always requested”. Research indicates that parents tend to avoid conversations such as contraception, abortion, or sexual identity until adolescence (El-Shaieb & Wurtele, 2009).

Two respondents indicated that one reason they have struggled with the topic of children’s sexual development when supporting families is that families do not ask for the information. However, children’s learning opportunities may be missed if parents and/or children wait too long to engage in the conversation (Cox et al., 2010; Murphy & Young, 2005). Respondents did not indicate that family resource centre policies impact their decision to deliver children’s sexual development information in service delivery,
and none of the respondents felt that they did not have coverage or time or were lacking professional support in order to attend available training opportunities. One respondent indicated that there were financial restraints in being able to attend training opportunities on children’s sexual development, and two reported that there were no available opportunities. None of the responses indicated that they felt unsupported by their administration to offer support regarding children’s sexual development. These responses indicate a deviation from what has been presented in the literature: that the role of sexuality educator can be difficult as the balance of providing comprehensive education to students and respecting the expectations of families and staff is precarious, reflecting a need for administrative support in adopting inclusion policies that reflect diversity in gender, race, culture, ability, and sexual identity (Sausa, 2005; Suter et al., 2012). Responses indicated a family-centered approach to the provision of sexuality education; for example: “our programs are participant driven, a program would be offered based on parents [sic] interest”, and “If participants requested a program around this topic we would make it available”, further reflecting an ecological systems theory, as families impact-and are impacted by- their children and their community.

Respondents cited a number of reasons they have struggled with the topic of children’s sexual development when supporting families. Reasons included inadequate knowledge (n=1), not wanting to offend families (n=1), they believe it to be outside of their scope of practice (n=1), and they do not want to give families inaccurate information (n=2). Considering these reasons is important, as teachers’ beliefs impact their service delivery. One respondent did indicate that “It would depend on a program facilitator and whether or not they include information or bring in guest speakers, this
topic is always encouraged but not part of a policy”, reflecting a need to examine policies and practices at an individual, program, and community level.

No respondents indicated that they prioritized other topics over children’s sexual development, or that the children of the families they support were too young, nor did any express embarrassment about the topic. Respondents were asked to share examples of materials they use to support children and families with sexuality education. Two respondents indicated that they use the Nova Scotia Department of Health and Wellness’s “Talk Sex” brochure, a two page brochure for families with children from birth to four years of age. One respondent reported that there are kits available at the sexual health centre, with whom they share a building, however, did not indicate having any brochures themselves. Future research into the knowledge and skills of sexual health centre staff in Nova Scotia may be of interest in determining whether materials are developmentally appropriate. One respondent shared examples of books used to support families, including “My Body, My Self”, “Sex, Boys and You”, and “What’s Happening to my Body” which, according to online reviews is written for 9-12 year olds, 11-19 year olds, and preteens respectively, which may indicate a lack of developmentally appropriate materials for supporting young children’s healthy sexual development. Other books cited included “The Barenaked Book” (n=3), “What’s the Big Secret?” (n=1), “Where Did I Come From?” (n=1), and “It’s so Amazing” (n=1), which are all written for preschool children. One resource cited, the Red Cross’ “Your Body is Yours” is available in English and French. Only one respondent reported having inadequate materials to support families, which is reflected in the literature, where although preschool teachers felt that sexuality education and attention to sexual development is important, they had
inadequate access to teaching supplies (e.g., books, toys) and training opportunities (Kakavoulis, 1998; Lai, 2006; Menmuir & Kakavoulis, 1999).

In considering diverse learning styles, it is important to recognize evidence-based teaching styles and effective learning strategies that children are already responding to in order to deliver developmentally appropriate education (Murphy & Young, 2005). Although nearly one third of students who are Deaf did not indicate challenges with accessing information, Suter et al. (2012) found that, of those who did, children who are Deaf and use sign language preferred visual materials, whereas children who are deaf and lip read preferred written supplemental materials. Therefore, as suggested by Getch et al. (2001), resources for learners with hearing loss should include visual and tactile components and video role modelling. Additionally, children with autism spectrum disorder benefit from techniques already proven successful, such as applied behaviour analysis, reinforcement schedules, social stories, and video modelling (Ballan, 2012; Chan & John, 2012; Gougeon, 2010). Children with vision loss may benefit from age-appropriate tactile learning opportunities, Braille, and auditory learning materials, though these opportunities are currently limited due to lack of adequate materials (Dodge, 1979; Kapperman & Kelly, 2013; Kelly & Kapperman, 2012; Philander & Swartz, 2006). Recommendations for contextualized learning are echoed for children with other developmental disabilities, including the use of anatomically correct dolls, providing modifications, and specialized teaching (Murphy & Young, 2005). Additionally, materials often do not allow discussions about, or materials referencing, diversity in sexual identity, unless from a victim stance, which may serve to pathologize or shame those individuals (Buck & Parrotta, 2014; McCarty-Caplan, 2013). A systematic review
of materials available for young children may be helpful in understanding whether materials are developmentally appropriate, inclusive, and accessible.

**Sexual Abuse**

Respondents were asked for their comfort level in supporting families with topics pertaining to sexual abuse. Specifically, the average comfort level for the topic of sexual abuse prevention was 3.4 out of 5, and concerns about a child having experienced sexual abuse was also 3.4 out of 5. Three respondents indicated that they wanted training on child sexual abuse, three had attended training in the topic while employed at the family resource centre, and two respondents had pre-service training on the topic. Family resource centre employees have a mandate to report suspected sexual abuse, and therefore must be educated in the signs and symptoms of children’s sexual abuse (Rheingold et al., 2012). However, responses regarding comfort level of supporting families with topics such as “their child having experienced sexual abuse”, and “sexual abuse prevention” indicated that there was a range of comfort with this particular topic. Whereas pre-service training about children’s sexual abuse was higher than other topics related to children’s sexual development (n=2), was higher than other areas of PD obtained (n=3), and was listed higher as an area of PD respondents were interested in (n=3), it may be a reflection of a risk-based education system that is rooted in abuse-prevention rather than in rights-based sexuality education. Williams et al. (2013) describe a sex-positive approach as including “sexual identities, orientations, and behaviours; gender presentation; accessible health care and education; and multiple important dimensions of human diversity” (p. 273). A sex-positive approach which encompasses both freedom from (e.g., from abuse, from being objectified) and freedom
to (e.g., explore sexuality, be able to “say no to sex as they choose”), could enhance children’s sexual development and engagement in sexuality education, (Fahs, 2014, p. 282).

**Race**

Three respondents indicated that they had had pre-service training related to racial diversity, though only one had received pre-service training about racial diversity specifically related to sexuality. One respondent had attended PD on racial diversity and sexuality while in the field. In terms of service delivery, race was reflected minimally in materials for families: individual support (n=0), workshops (n=1), brochures and pamphlets (n=1), books (n=2); and slightly more represented in materials for children: individual support (n=2), toys (n=3), and books/brochures/pamphlets (n=2). One respondent indicated that they would find PD opportunities specific to racial diversity and sexuality development and education helpful.

The reinforcement of privilege is seen in wider, cultural conversations which may portray white, middle-class females as sexually vulnerable, and white, middle-class males as heterosexual whereas racial minorities were often portrayed as sexually deviant, “bad girls– sexually raw, assertive and immoral”, and their sexuality was most often focused in preventative measures (Buck & Parrotta, 2014; Froyum, 2010, p. 59-60; Lewis, 2004). Froyum (2010) expands on this stereotyped representation, sharing that “policymakers and the media disseminate stereotypical images of black girls as gender deviants who are too sexually expressive and, therefore, unfeminine by middle-class white standards” (p. 61). Therefore recognizing racial diversity is imperative in the provision of sexuality education.
Culture

Whereas sexuality is a value-laden topic, it is evident that different cultures have different expectations, morals, values, beliefs, attitudes and comfort levels for the provision- and impact- of sexuality education for young children (Kakavoulis, 1998; Tutty, 2000; Winders Davis et al., 2013). Three respondents indicated that they had had pre-service training related to cultural diversity, though only one had received pre-service training about cultural diversity specifically related to sexuality. Two respondents had attended PD on cultural diversity and sexuality while in the field. In terms of service delivery, culture was reflected minimally in materials for families: individual support (n=2), workshops (n=1), brochures and pamphlets (n=1), books (n=1); and slightly more represented in materials for children: individual support (n=2), toys (n=1), and books/brochures/pamphlets (n=1). Two respondents indicated that they would find PD opportunities specific to cultural diversity and sexuality development and education helpful. Hingsburger (1993) defines sexuality as “ways in which people define themselves, the ways they define others, and the way and the personal or cultural interpretations they apply to human relationships” (p. 8), reinforcing the importance of understanding culturally diverse practices in relation to sexuality education.

Religion

Three respondents indicated that they had had pre-service training related to religious diversity, though only one had received pre-service training about religious diversity specifically related to sexuality. One respondent had attended PD on religious diversity and sexuality while in the field. In terms of service delivery, religion was least reflected in materials for families: individual support (n=0), workshops (n=1), brochures
and pamphlets (n=1), books (n= 1); and in materials for children: individual support (n=1), toys (n=0), and books/brochures/pamphlets (n= 0). One respondent indicated that they would find PD opportunities specific to religious diversity and sexuality development and education helpful. Religious values may also impact how sexuality education is provided. El-Shaieb and Wurtele (2009) found that religiosity may be negatively correlated with the provision of sexuality education; that is, parents who were more religious often delayed initiating sexuality education by three years as compared with their less religious counterparts (Arademi & Pillay, 2013). Religion may impact the service delivery of sexuality education as it impacts how values are expressed, especially regarding topics such as contraception, timing of intercourse (e.g., premarital sex), sexual identity, acceptable sexual acts, and self-pleasure, at each an individual, familial, and community level.

Ability

Much of the sexual development scholarship and educational engagement has been situated in what is termed as “typical”, or “expected”, development, which has created a gap for children who experience developmental delays (Miltenberger et al., 1999; O’Dea, Shuttleworth, & Wedgwood, 2012). Individuals with impairments are often not included in the discourse of sexuality education, despite higher sexual abuse rates (Foster & Sandel, 2010; Stewart, 2012). Responses from the present study indicated that some pre-service training about ability diversity in relation to sexual development had been attended (i.e., one respondent had pre-service training to all areas of disability noted; one had pre-service training related to physical disability, and one related to Autism spectrum disorder). One respondent had pre-service training related to
all areas of disability mentioned specific to children’s sexual development. Two respondents had attended PD on ability diversity and sexuality while in the field. In terms of service delivery, ability was nominally reflected in materials for families: individual support (n=1), workshops (n=2), brochures and pamphlets (n=1), books (n= 2); and slightly less represented in materials for children: individual support (n=2), toys (n=1), and books/brochures/pamphlets (n= 1). Three respondents indicated that they would find PD opportunities specific to ability diversity and sexuality development and education helpful. It is clear that “all individuals with disabilities have a right to education about sexuality” (p. 682), and therefore, all educators should be equipped to respond to individual learning styles and support strategies (Ballan, 2012).

**Sexual Identity**

None of the respondents indicated that they had had pre-service training related to sexual identity (e.g., LGBTQ, two-spirit) diversity, either generally or specific to children’s sexual development, though two respondents had attended PD on the topic while in the field. In terms of service delivery, sexual identity was reflected minimally in materials for families: individual support (n=1), workshops (n=2), brochures and pamphlets (n=1), books (n= 3); and slightly less represented in materials for children: individual support (n=2), toys (n=0), and books/brochures/pamphlets (n= 1). Responses ranged regarding staff comfort levels with the topic of sexual identity, with an average comfort rating of 3.2 out of 5. Three respondents indicated that they would find PD opportunities specific to sexual identity diversity and sexuality development and education helpful. Four years of age is typically when children begin asking where babies come from, while by five, many have a preliminary concept of sex; however, early
sexuality education rarely addresses sexual identity and contraception (Kakavoulis, 1998; Walker and Milton, 2006). Challenging heteronormativity serves to benefit both the student and the learning environment as a whole, supporting the creation of “learning environments that facilitate critical thinking, civic and scholastic engagement, academic achievement, and social/emotional learning of all students” (McCarty-Caplan, 2013, p. 259).

**Gender**

Diversity in gender was reportedly reflected in individual family support (n=5), individual spot for children (n=4) workshops provided to families (n=3), books for families (n=4), toys for children (n=3), books, brochures, and/or pamphlets for children (n=3). Responses to the question of how comfortable staff were supporting families with the topic of gender reflected a range, with an average comfort level of 3.6 out of 5. However, none of the respondents had pre-service training in gender diversity, and only two had PD about gender diversity while in the field. Three respondents indicated that they would find PD opportunities specific to gender diversity in sexuality development and education helpful. Children’s gender identity (i.e., how an individual views their gender) typically emerges between two and four years of age, as they can identify their own gender and the genders of others, whereas gender constancy (i.e., the understanding that one’s gender is stable) emerges between five and seven years (Mallon & DeCrescenzo, 2006; Menvielle, 2009; Stieglitz, 2010). Children who identify as trans (i.e., individuals whose given gender does not align with their perception of their own gender) often identify their gender variance (i.e., gender outside of the “norms” of masculine/feminine) in the preschool years, as they begin to develop language and
thinking skills (Luecke, 2011; Menvielle, 2009; Stieglitz, 2010). According to Mallon and DeCrescenzo (2006), schools are often the least trans-affirming environments for children, as divisions between genders become more pronounced. Many teachers felt unprepared and unskilled in teaching acceptance of children who do not identify within the gender binary of male/female, which may be reinforced by the fact that in pre-service education texts, sexual and gender identities are often rooted in victimization, placed in chapters about mental health and Sexually Transmitted Infections (Duke & McCarthy, 2009; Payne & Smith, 2014).

Young children are socialized across multiple contexts to fit within gender norms, such as through the reinforcement of gendered play (e.g., dolls for girls), and parents are typically encouraged to perpetuate these expectations (Dykstra, 2005; Kuvalanka, Weiner, & Mahan, 2014; Mallon & DeCrescenzo, 2006). Gender inequality is evident in the provision of sexuality education, as the notion of female empowerment is often rejected in sexuality education, limiting pleasure-centered sexuality, oppressing females based on gender, restricting their ability to be educated and in control of their own sexuality (Lamb et al., 2013; Oliver et al., 2013; Preston, 2013). Males are likewise limited by this idea of pleasure, as they may be limited by a socially constructed heterosexual, biological imperative, rather than an emotional/relational one (Buck & Parrotta, 2014; Oliver et al., 2013). Therefore, recognizing the role of gender in sexual development and sexuality education may enhance inclusive sexuality education in the early years.
Language Diversity

Regarding language diversity and sexuality education, two respondents had training on the topic while in the field, and one reported that training on the topic would be helpful. In terms of service delivery, language diversity was rarely reflected in materials for families: individual support (n=1), workshops (n=2), brochures and pamphlets (n=1), books (n= 2); and for children: individual support (n=2), toys (n=0), and books/brochures/pamphlets (n= 1). This is notable as approximately 91.8% of Nova Scotians identify English as their primary language, whereas 3.4% identified French, 0.5% Mi’kmaq, and 3.6% Arabic, in addition to other languages identified (Statistics Canada, 2015). Having materials available in a variety of languages would help all children and families have access to sexuality education. Anecdotally, in workshops presented by the writer, it is evident that anatomical names for various body parts vary across cultures, origins, and age. According to Kenny et al. (2008), “knowledge of the correct terminology for genitals is deemed critical to others’ response to children’s disclosure as abuse” (p. 37). Aside from understanding anatomy, recognizing language diversity is imperative working from a family centered lens, one that encompasses “beliefs, principles, values and practices for supporting and strengthening family capacity to enhance and promote child development and learning” (Dunst, 2002, p. 139).

Family Composition

Three respondents indicated that they had had pre-service training related to family composition diversity, and two had received pre-service training about family composition diversity specifically related to sexuality. Two respondents had attended PD on family composition diversity and sexuality while in the field. In terms of service
delivery, family composition was more frequently included in materials for families: individual support (n=4), workshops (n=3), brochures and pamphlets (n=1), books (n= 3); and slightly more represented in materials for children: individual support (n=2), toys (n=1), and books/brochures/pamphlets (n= 2). Two respondents indicated that they would find PD opportunities specific to family composition diversity and sexuality development and education helpful. Throughout the research, there is evidence of a belief that children who are part of heterosexual families do not need to learn about families who are not heterosexual; however, this silence serves to reinforce heteronormativity and heterosexism, and can limit learning opportunities about diversity, power, and discrimination (Robinson & Davies, 2008; Surtees, 2008).

**Comfort and Support**

It appeared in the present research that the topics family resource centre staff identified as being most comfortable with were also the topics that they perceived families to be asking for support with most often. Two possible explanations will be explored: relationship based intervention and comfort with facts versus values. In terms of relationship-based intervention, it may be that families are comfortable asking for support with topics because staff are comfortable with the topics. This relationship may be reciprocal: the more comfortable families are in asking, the more comfortable the staff would be in providing support, and vice versa- when staff are more comfortable, families might be more willing to seek support. These results may be similar to how families are perceived by their children as sexuality educators; parents who conversed more frequently on the topic of sexuality were viewed as more comfortable by their children, and parents who were viewed as more “askable” had children who were considered to be
more confident about sexual matters (Angera et al., 2008; Walker, 2004). Within the mesosystem, building family capacity can support children’s development, generalization, and maintenance of appropriate skills and behaviours (Gurol, Polat, & Oran, 2014; Swango-Wilson, 2010).

The topics rated as both most comfortable for staff and perceived by respondents as most asked for by families (i.e., protective methods (e.g., condoms, birth control), naming body parts, childbirth, and procreation (where babies come from)) appear to be rooted in facts, rather than values, and are generally considered more socially acceptable. Topics which were commonly shared as least comfortable by staff and perceived by staff as least sought after by families included consent, sexual identity (e.g., LGBTQ, two spirit), and privacy, topics which tend to reflect each cultural, familial, and individual values and are generally more socially taboo. However, these “taboo” topics are essential. For example, understanding privacy allows children to recognize that they have control over their own bodies and that they have the right to decide where and when they touch others, are touched by others, are naked, or are having conversations about personal matters (Hollomotz & The Speakup Committee, 2008; Rashikj & Trajkovski, 2009; Sakellariou, 2012). “Students excluded from accessing a curriculum that teaches them about their rights and responsibilities are more apt to have those rights abused” (Gougeon, 2009, p. 286). Additionally, without the opportunity to provide consent/dissent, there is evidence that children and youth may believe that “someone else decides about the level of their sexual experience and their levels of sexual knowledge” (Anderson & Kitchin, 2000, p. 1166).
This relationship between comfort level and value-based education is evident in the literature as parents often report feeling uncomfortable educating their children about sexuality, as they feel unprepared, embarrassed, unskilled, fearful, and may lack confidence or clarity in their values (Job, 2004; Kenny, 2009; Lai, 2006). During the early years, children are internalizing cultural norms, values and expectations, as well as developing an understanding of “societal structures of power, privilege, and oppression” (Parent et al., 2013, p. 641). This reflects a need to root sexuality education in value-based education. Often, this informal education is referred to as the hidden curriculum, which “contains unspoken rules, social values, attitudes, and norms” (p. 141) which are not explicitly taught (Lee, 2010). Comprehensive sexuality education includes “acquiring knowledge, developing skills, and forming positive behaviours, values and attitudes” (Walker & Milton 2006, p. 419), and emphasizes communication and exploration of “values, goals and options” (McCarty-Caplan, 2013, p. 253) (Matziou et al., 2009; Roberts & Miltenberger, 1999; Suter et al., 2012). Therefore, the importance of responding to the challenges associated with rooting sexuality education in values cannot be understated.

**Seeking Additional Support**

When additional support is sought, it would seem that some referrals are being made to external programs. According to the literature, many teachers feel unprepared and out of their scope of expertise to offer sexuality education and some educators also expressed concerns that providing inaccurate or incomplete information would be dangerous, perhaps even prompting sexual behaviours (Fader Wilkenfeld & Ballan, 2011; Povilaitiené & Radzeviciené, 2013). Within the present study, two respondents indicated
that they struggled with supporting children’s sexual development as they did not want to give families inaccurate information, and one felt that it was out of their scope of practice.

Early childhood educators were not cited as a source for referral by the respondents, despite the literature stating that children are part of a greater culture, made up of parents, educators, and others in their communities and educational environments, and it is imperative that these networks work together to support learning and create safety for children (Aderemi & Pillay, 2013; Gougeon, 2010; Kenny et al., 2008; Leclerc et al., 2011; Povilaitiené & Radzeviciené, 2013; Randolph & Gold, 1994; Tutty, 2000; Winders Davis et al., 2013). Moreover, Roberts and Miltenberger (1999) found that programming was more effective when provided by an individual’s parents and teachers who are familiar with the child and their individual strengths and areas and styles for learning (Swango-Wilson, 2010). Classroom teachers can be valuable resources in providing sexuality education to students, as they have access to information and resources, and can promote an inclusive learning environment, teaching acceptance, diversity, and inclusion, and challenging prejudice and “otherness” (Duke & McCarthy, 2009; East & Orchard, 2014; Fader Wilkenfeld & Ballan, 2011). Therefore, supporting outside referrals is valuable, however, it could be worthwhile to examine how these programs are able to provide developmentally appropriate sexuality education and family-centered support for families as sexuality educators.

Respondents also did not indicate making referrals to the following professionals: Occupational Therapists, APSEA (Atlantic Province Special Education Authority), EIBI (Early Intensive Behaviour Intervention Program), or psychologists, each of whom could
provide developmentally appropriate support on a variety of topics pertaining to children’s sexual development and sexuality education. It could be helpful to determine the capacities of each of these resources, and to understand how to enhance partnerships and encourage referrals if appropriate.
CHAPTER VII

Conclusion

“During early youth, children are forming cultural identities, friendships, developing opinions, and appreciating others” (p. 117), which speaks to a need for the provision of comprehensive, inclusive sexuality education for all children in the early years (Flores, 2014). In a study cited by Kakavoulis (1998), it was acknowledged that a child “must be seen as a sexual being, in whom sexuality is a dynamic force in total personality development, a force determining as much of his or her happiness and fulfillment as in adulthood” (p. 57). As such, sexuality must be valued as “a normative and positive aspect of child development” (Dewinter et al., 2013, p. 3468).

This study used an individual electronic survey method in an effort to understand of how family resource centres are supporting families in their provision of inclusive sexuality education to their young children. The research questions were as follows;

- What information, support, and resources do family resource centre staff feel are being asked for by families? When appropriate, to whom are family resource centre staff referring families for additional support in supporting their child’s sexual development?

- What resources are accessible at family resource centres for families regarding their young children’s sexual development? How do these resources embrace diversity in areas such as culture, ability, sexual identity, and gender?

- What resources are available at family resource centres that directly engage young children (birth to school age) in promoting healthy sexual development?
How is diversity in areas such as culture, ability, sexual identity, and gender reflected?

- What education is offered to family resource centre staff to provide information about children’s healthy sexual development during the early years (birth to school entry)? What learning opportunities would be helpful?

Implications

Although there are certainly limitations to this study, there are implications for training institutions, family resource centres, and sexuality educators. All respondents indicated wanting professional development pertaining to children’s sexuality; however, whereas there appeared to be gaps in the provision and thoroughness of preservice training and professional development, training institutions may benefit from reviewing opportunities for enhanced learning in this particular area, be it by incorporating sexual development into core programming, developing courses specific to children’s sexual development, or by offering ongoing professional development opportunities.

Family resource centres appeared to be well positioned to support families in the provision of developmentally appropriate, inclusive sexuality education. Although respondents reportedly felt supported by their administration in offering family centered sexuality education, it may be valuable to examine resources and materials available to determine accessibility and inclusion to ensure that all families and children are reflected and able to engage in programming. Furthermore, it may be helpful to reinforce community partnerships to ensure that collaborative practices continue to evolve to meet the needs of all families.

The research may have implications for all sexuality educators, both formal and informal, as a number of insights were discovered. Firstly, respondents perceived
families to be seeking information and support, which reflects an opportunity for the provision of early, family-centered sexuality education, which may inform the practices of current early years professionals. This may also inform curriculum development, as there are a variety of topics that can be supported in early learning and care. Secondly, although materials do exist for supplementing children’s sexuality education, they may not necessarily be inclusive or developmentally appropriate. This is important to consider, as although nearly half of parents engage their young children in sexual abuse education, they often do not have access to developmentally appropriate materials such as books, videos, and puppets, which could help children to better understand abstract concepts (Kenny, 2009; Kenny et al., 2008; Tutty, 2000; Walker & Milton, 2006). Identifying and using inclusive materials and teaching strategies can help to engage all families and children in a meaningful curriculum (Glazzard, 2013).

Limitations and Calls for Future Research

Limitations exist that may hinder the application of these results. Specifically, a low return rate (n=5) impacts the generalizability of the results, as the respondents certainly cannot speak to all successes, gaps, and opportunities for all family resource centres. Within the low return rate, it is notable that all centres identified as serving rural communities, and, although 44% of all Nova Scotians live in rural communities, these results may not reflect the experiences of all family resource centres in Nova Scotia, and their access to professional development and community resources, which may be different in an urban setting (Gahagan, Rehman, Barbour, & McWilliam, 2008). Extending the population to include family resource centres in other provinces may add valuable information, deepening the research on how family resource centres are
supporting families in their provision of inclusive sexuality education to their young children. Using a survey method may have limited the results, as there were no opportunities to expand on responses or to deepen the conversation to allow for more insight into the topic. Moreover, because the survey was an anonymous online survey, there was no opportunity for follow up questions to determine the “why”s behind the questions as may be desired. Future research could adopt a method (e.g. interviews or focus groups), or engage a different population, which could allow for deeper exploration of the topic.

Additionally, families were not directly involved in the research, and even within the study, family resource centre staff were only able to reflect on the experiences of families who were accessing the family resource centre, and therefore some families may not have been reflected in the responses. This distinct lack of a family voice may impact the application of the research to answering how families are engaging in sexuality education with their young children, what supports they are accessing, and what resources they are looking for. Future research including the voices of families could aid understanding of children’s healthy sexual development and sexuality education.

Furthermore, because inclusion was intended to be at the forefront of the research, it is imperative that future research includes voices and materials that reflect that diversity. Whereas the researcher’s lens is that of an educated, cis-female, able, Caucasian, heterosexual, English-language using, Canadian individual, it is notable that her lens may impact her experience within a diverse society, and future research could benefit from a “nothing about me without me” approach, examining the experiences of all individuals in sexual development and sexuality education. Specifically, because the survey was
distributed in English only, the experiences of diverse language speakers in Nova Scotia (e.g., aboriginal communities, Acadian communities) may not have been reflected. Additionally, in analyzing the materials for diversity, it is unclear what the respondents used as determining factors to conclude that their materials and approaches were, or were not, inclusive of various elements of diversity (e.g., race, gender, culture, religion, ability, sexual identity, family composition, language, and age).

**Future Research**

In reviewing possible gaps in the present study, the following emerged as areas for future research: a review of the materials and resources currently being used, and those which are otherwise available, to determine how they reflect inclusion and developmentally appropriate practice; a study determining what families are currently doing to support their children’s healthy sexual development in the early years, and what supports could help build their capacities within that role; what training exists (pre-service and ongoing) to build capacity of sexuality educators; how does pre-service training and professional development impact service delivery; and a geographic widening to determine experiences of family resource centres outside of Nova Scotia.

**Summary**

Using an online survey, the present study sought to find out how family resource centres in Nova Scotia are supporting family-centered, inclusive sexuality education in the early years. Five respondents, all of whom supported families in rural communities shared examples of materials, resources and supports used when helping families, and provided the researcher with an understanding of how diversity is reflected in materials. Respondents perceived families to be looking for support in the preschool years (3-6
years) and felt that families are asking for the same information as staff are comfortable with, which may reflect a general societal comfort level with various topics (e.g., value-based as less comfortable than fact-based), or may reflect the impact of relationship based interventions. Pre-service training and professional development did not appear to enhance comfort levels with sexuality education, though all respondents indicated wanting more training opportunities on the topic. In providing sexuality education for young children, it is important to consider Bronfenbrenner’s ecological systems theory, recognizing that children impact- and are impacted by- their families, communities, and culture, and that how sexuality education is delivered is likewise impacted by these elements. Similarly, Lewis (2004) described responsible sexual behaviours as “expressed at individual, interpersonal and community levels…characterized by autonomy, mutuality, honesty, respectfulness, consent, protection, pursuit of pleasure and wellness” (p. 227). Therefore, it is essential to consider sexual development and sexuality education from a holistic, developmentally appropriate lens which emphasizes rights, values, and inclusion, a practice which seems to have been embraced by the five family resource centre staff who participated in this study.
References


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disabilities. *Sexuality and Disability, 29*(2), 129–141.


Gougeon, N. A. (2009). Sexual education for students with intellectual disabilities, a


Nichols, S., & Blakeley-Smith, A. (2009). “I’m not sure we’re ready for this…”:


Appendix A
# Appendix A: Family Resource Centres and Contact Information

<table>
<thead>
<tr>
<th>Name of Centre</th>
<th>E-Mail Contact</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bayers/Westwood Family Support Centre</td>
<td><a href="mailto:ed@bayerswestwoodfrc.com">ed@bayerswestwoodfrc.com</a></td>
<td>Central</td>
</tr>
<tr>
<td>Dartmouth Family Centre</td>
<td><a href="mailto:info@dartmouthfamilycentre.ca">info@dartmouthfamilycentre.ca</a></td>
<td>Central</td>
</tr>
<tr>
<td>Eastern Shore Family Resource Association</td>
<td><a href="mailto:esfamilyresource@ns.aliantzinc.ca">esfamilyresource@ns.aliantzinc.ca</a></td>
<td>Central</td>
</tr>
<tr>
<td>East Preston Day Care Family Health Resource Centre</td>
<td><a href="mailto:trinabrooks@hotmail.com">trinabrooks@hotmail.com</a></td>
<td>Central</td>
</tr>
<tr>
<td>Fairview Family Centre</td>
<td><a href="mailto:info@ffcns.ca">info@ffcns.ca</a></td>
<td>Central</td>
</tr>
<tr>
<td>Family SOS</td>
<td><a href="mailto:info@familysos.ca">info@familysos.ca</a></td>
<td>Central</td>
</tr>
<tr>
<td>Halifax Military Family Resource Centre</td>
<td><a href="mailto:info@halifaxmfc.ca">info@halifaxmfc.ca</a></td>
<td>Central</td>
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<tr>
<td>Chebucto Family Centre</td>
<td><a href="mailto:info@hgalhfx.ca">info@hgalhfx.ca</a></td>
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<tr>
<td>Memory Lane Family Place Association</td>
<td><a href="mailto:children@accesswave.ca">children@accesswave.ca</a></td>
<td>Central</td>
</tr>
<tr>
<td>Mi'kmaq Child Development Centre</td>
<td><a href="mailto:medcals@ns.aliantzinc.ca">medcals@ns.aliantzinc.ca</a></td>
<td>Central</td>
</tr>
<tr>
<td>Mi'kmaq Native Friendship Centre</td>
<td><a href="mailto:Pamglode@gmail.com">Pamglode@gmail.com</a></td>
<td>Central</td>
</tr>
<tr>
<td>Mulgrave Park Caring &amp; Learning Centre</td>
<td><a href="mailto:caring.learning@eastlink.ca">caring.learning@eastlink.ca</a></td>
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</tr>
<tr>
<td>Musquodoboit Valley Family Resource Centre</td>
<td><a href="mailto:mvfrc@staff.ednet.ns.ca">mvfrc@staff.ednet.ns.ca</a></td>
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<td>North End Parents Resource Centre</td>
<td><a href="mailto:parentresource@hotmail.com">parentresource@hotmail.com</a></td>
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<td>Parents And Children Together Resource Centre</td>
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<tr>
<td>Shearwater Military Family Resource Centre</td>
<td><a href="mailto:info@halifaxmfrc.ca">info@halifaxmfrc.ca</a></td>
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</tr>
<tr>
<td>Cape Breton Family Resource Coalition Society</td>
<td><a href="mailto:jlatulippe-rochon@familyplace.ca">jlatulippe-rochon@familyplace.ca</a></td>
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</tr>
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<td>East Hants Family Resource Centre</td>
<td><a href="mailto:ehfamilycentre@gmail.com">ehfamilycentre@gmail.com</a></td>
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<td>Kids First Association (inc. Guysborough, Antigonish, New Glasgow)</td>
<td><a href="mailto:mward@kids1st.ca">mward@kids1st.ca</a></td>
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<tr>
<td>Maggie's Place (Amherst)</td>
<td><a href="mailto:maggies@ns.sympatico.ca">maggies@ns.sympatico.ca</a></td>
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<tr>
<td>Maggie's Place - Colchester</td>
<td><a href="mailto:info@maggiesplace.ca">info@maggiesplace.ca</a></td>
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<td>Appletree Landing Children's Centre</td>
<td><a href="mailto:atl@bellaliant.com">atl@bellaliant.com</a></td>
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</tr>
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<td>Bridgewater Family Support Centre</td>
<td><a href="mailto:cushintb@gov.ns.ca">cushintb@gov.ns.ca</a></td>
<td>Western</td>
</tr>
<tr>
<td>Le Centre Provincial de Ressources Prescolaires</td>
<td><a href="mailto:suzanne@cprps.ca">suzanne@cprps.ca</a></td>
<td>Western</td>
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<td>Chester and Area Family Resource Centre</td>
<td><a href="mailto:cafrc@ns.aliantzinc.ca">cafrc@ns.aliantzinc.ca</a></td>
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<td>Digby County Family Resource Centre</td>
<td><a href="mailto:thefamilycentre1@bellaliant.com">thefamilycentre1@bellaliant.com</a></td>
<td>Western</td>
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<td>Family Resource Centre of West Hants</td>
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<td>Greenwood Military Family Resource Centre</td>
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</tr>
<tr>
<td>Kids Action</td>
<td><a href="mailto:daphne.goodine@northnovacable.ca">daphne.goodine@northnovacable.ca</a></td>
<td>Western</td>
</tr>
<tr>
<td>Family Resource Centre</td>
<td>Email Address</td>
<td>Region</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>--------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Kings County</td>
<td><a href="mailto:family.centre@ns.sympatico.ca">family.centre@ns.sympatico.ca</a></td>
<td>Western</td>
</tr>
<tr>
<td>New Ross</td>
<td><a href="mailto:nrfrc@ns.sympatico.ca">nrfrc@ns.sympatico.ca</a></td>
<td>Western</td>
</tr>
<tr>
<td>South Shore Family Resource Association (Better Together</td>
<td><a href="mailto:capc.bri@ns.sympatico.ca">capc.bri@ns.sympatico.ca</a></td>
<td>Western</td>
</tr>
<tr>
<td>South Shore Family Resource Association (Queens Family</td>
<td><a href="mailto:qfrc@ns.aliantzinc.ca">qfrc@ns.aliantzinc.ca</a></td>
<td>Western</td>
</tr>
<tr>
<td>South Shore Family Resource Association (King Street</td>
<td><a href="mailto:capcshel@ns.sympatico.ca">capcshel@ns.sympatico.ca</a></td>
<td>Western</td>
</tr>
<tr>
<td>Parents Place Yarmouth Family Resource Centre</td>
<td><a href="mailto:parentsplace@eastlink.ca">parentsplace@eastlink.ca</a></td>
<td>Western</td>
</tr>
</tbody>
</table>
Appendix B

Invitation for Executive Directors

Title of Study: Family-Centered Support for the Provision of Inclusive Sexuality Education for Children in the Early Years

Student Principle Researcher: Emily Martinello, Master’s student, Department of Child and Youth Study, Mount Saint Vincent University

Faculty Supervisor: Dr. Devi Mucina, Assistant Professor, Department of Child and Youth Study, Mount Saint Vincent University

I would like to invite you and your staff to participate in a research study on how families are supported in the provision of inclusive sexuality education to their young children (birth to school entry). I am looking for participants who support families with young children (birth to school entry) and who are currently employed at one of Nova Scotia’s 28 family resource centres. I am asking you to please forward this email, including the attachments, to all of your staff at the family resource centre. The aim of this research is to gain deeper insight into how family resource centres are supporting inclusive, family-centred sexuality education in the early years. Information gained from this research can be used to enhance our understanding and knowledge of the issues and challenges confronting family resource centres when providing support to families with regards to supporting children’s healthy sexual development. Once completed, a summary of the findings will be shared with you to share with your staff. Please note that the link to the survey will remain open until November 9, 2015 at midnight, at which time interested participants will no longer have access to participate in the research.

Should you have any further questions or concerns regarding this study, please contact either Emily Martinello at (Emily.Martinello@msvu.ca) or Dr. Devi Mucina at (Devi.Mucina@msvu.ca). If you have questions about how this study is being conducted and wish to speak to someone who is not directly involved in the study, you may contact the Chair of the University Research Ethics Board c/o MSVU Research and International Office at 457-6350 or via e-mail at research@msvu.ca.

Thank you for considering this research project, and for inviting your staff to do the same.

Sincerely,
Appendix C
Invitation to Participate

Title of Study: Family-Centered Support for the Provision of Inclusive Sexuality Education for Children in the Early Years

Student Principle Researcher: Emily Martinello, Master’s student, Department of Child and Youth Study, Mount Saint Vincent University

Faculty Supervisor: Dr. Devi Mucina, Assistant Professor, Department of Child and Youth Study, Mount Saint Vincent University

I would like to invite you to participate in a research study on how families are supported in the provision of inclusive sexuality education to their young children (birth to school entry). I am looking for participants who support families with young children (birth to school entry) and who are currently employed at one of Nova Scotia’s 28 family resource centres. The aim of this research is to gain deeper insight into how family resource centres can support inclusive, family-centred sexuality education in the early years. Information gained from this research can be used to enhance our understanding and knowledge of the issues and challenges confronting family resource centres when providing support to families with regards to supporting children’s healthy sexual development.

Statistics Canada (2011) found that almost 55,000 Canadian children experienced sexual abuse in 2009, and research indicates that 30% of child sexual abuse is initiated before the child is six years old (Kenny, 2009; Roberts & Miltenberger, 1999). These statistics reflect a pertinent need: to support children’s developing sexuality in order to address both abuse prevention and the foundation of healthy relationships across the lifespan. For the purposes of this research, sexuality will be defined as a developmental process that is rooted in social practices, morals, religion, education, behaviour, and biology. Family resource centres are uniquely positioned to support children’s healthy sexual development, as staff engage both children and their families, and can support, empower, and educate families.

If you are willing to participate in an individual electronic survey on inclusive sexuality education in the early years, please complete the linked electronic consent form and survey (http://msvuchys.limequery.com/index.php/876565/lang-en). The survey should take approximately 30 minutes to complete and all responses will be submitted anonymously. Should you choose to participate, the link to the survey will remain open until November 9, 2015 at midnight, at which time you will no longer have access to participate in the research.
Please understand that your participation in this study is completely voluntary and that you may decline to participate at any time, without penalty. You may skip or decline to respond to any questions you wish. All information obtained in this study will be anonymous and kept strictly confidential and will not influence your employment. The results of this study will be presented as group data and no individual participants will be identified. Quotes from the surveys may be used in the thesis, however, no name or identifying information will be reported. Please note that, because all responses are anonymous, once you submit your survey, your responses cannot be withdrawn. Data collected will be included in a Master’s thesis, and may be used in the future for publication in academic journals and/or in the development of a training module to support family-centered, inclusive sexuality education in the early years. A summary of the findings will be shared electronically with all family resource centres in Nova Scotia when the study is completed, and/or can be obtained by contacting the researcher.

The ethical components of this research study have been reviewed by the University Research Ethics Board and found to be in compliance with Mount Saint Vincent University’s Research Ethics Policy.

Should you have any further questions or concerns regarding this study, please contact either Emily Martinello at (Emily.Martinello@msvu.ca) or the supervisor, Dr. Devi Mucina at (Devi.Mucina@msvu.ca). If you have questions about how this study is being conducted and wish to speak to someone who is not directly involved in the study, you may contact the Chair of the University Research Ethics Board c/o MSVU Research and International Office at 457-6350 or via e-mail at research@msvu.ca.

Thank you for considering this research project.

Sincerely,

____________________________
Emily Martinello
Masters Student
Mount Saint Vincent University

____________________________
Dr. Devi Mucina
Department of Child and Youth Studies
Mount Saint Vincent University
Appendix D
Appendix D

Informed Consent Form for Online Survey

You are being invited to participate in a research study titled “Family-Centered Support for the Provision of Inclusive Sexuality Education for Children in the Early Years”. This study is being done by Emily Martinello, a Masters student at Mount Saint Vincent University, under the direct supervision of Dr. Devi Mucina, with the Child and Youth Study Department. You were selected to participate in this study because you work with one of Nova Scotia’s 28 family resource centres.

The purpose of this research study is to learn how families are supported in the provision of inclusive sexuality education to their young children (birth to school entry). The researcher intends for this study to identify what resources and supports are available, and what gaps may be affecting how families access support for their children’s developing healthy sexuality. If you agree to take part in this study, you will be asked to complete an online survey. This survey will ask about your own training and training needs pertaining to children’s sexual development, and what kinds of information and support you are providing to families and children who access your family resource centre. It should take you approximately 30 minutes to complete.

You may not directly benefit from this research; however, we hope that your participation in the study may help to determine what opportunities exist for strengthening and for change, in order to support the healthy sexual development of all young children in Nova Scotia.

We believe there are minimal risks associated with this research study. Specifically, there may be increased psychological risks for participants, due to the sensitive nature of this topic. As such, we understand that some of the questions make evoke strong emotions and responses that you may wish to access support for. As researchers, we are not qualified to provide this level of support; however, we would encourage you to access supports available in your community and across the province. Although the attached list is by no means exhaustive, there are avenues to access publicly funded services that are available to support individuals who have experienced sexual abuse, either directly or indirectly. In the case of an emergency please call 911. Please note that both researchers are bound by law to report any confirmed or suspected instances of child abuse, and confidentiality cannot be maintained in this circumstance.
Your participation in this study is completely voluntary and you can withdraw at any time. You are free to skip any question(s) that you choose. Please note that, once you submit your survey by clicking “submit”, your responses cannot be withdrawn.

All responses will be submitted anonymously via LimeSurvey, and will be kept strictly confidential. Participation in this research will not influence your employment. The results of this study will be presented as group data and no individual participants will be identified. Quotes from the surveys may be used in the thesis, however, no name or identifying information will be reported. Please note that, because all responses are anonymous, once you submit your survey, your responses cannot be withdrawn. Data collected will be included in a Master’s thesis, and may be used in the future for publication in academic journals and/or in the development of a training module to support family-centered, inclusive sexuality education in the early years. A summary of the findings will be shared electronically with all family resource centres in Nova Scotia when the study is completed, and/or can be obtained by contacting the researcher.

If you have questions about this project or if you have a research-related problem, you may contact the researcher and her supervisor: Emily Martinello (Emily.Martinello@msvu.ca) or Dr. Devi Mucina (Devi.Mucina@msvu.ca) respectively. If you have questions about how this study is being conducted and wish to speak to someone who is not directly involved in the study, you may contact the Chair of the University Research Ethics Board c/o MSVU Research and International Office at 457-6350 or via e-mail at research@msvu.ca.

By clicking “I agree” below you are indicating that you agree to the following:
- I am at least 19 years of age
- I am currently employed at a Nova Scotian Family Resource Centre
- I support children- or families with children- in the early years (i.e., birth to school entry)
- I understand that I have the opportunity to ask questions at any time throughout the process
- I understand that my participation in this study is voluntary and I am able to withdraw at any time, and do not have to respond to every question if I do not wish to
- Once I click “submit”, my survey cannot be withdrawn from the research
- I have been informed of the potential risks and benefits of my participation in this study
- I have read and understood this consent form and agree to participate in the above named research study

Please print a copy of this page for your records.
Publicly Funded Services available include, but are not limited to:

<table>
<thead>
<tr>
<th>Service</th>
<th>Location/Region Served</th>
<th>Contact Information</th>
<th>How this service can offer support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services</td>
<td>All of Nova Scotia</td>
<td>9-1-1</td>
<td>“Connects the call to the emergency response centre serving that area”</td>
</tr>
<tr>
<td>Mental Health Crisis Line</td>
<td></td>
<td>1-888-429-8167 (toll free)</td>
<td>“Telephone crisis support and mobile response… available 24 hours a day, 7 days/week”</td>
</tr>
<tr>
<td>Mobile Crisis</td>
<td>Halifax Regional Municipality</td>
<td>(902) 429-8167</td>
<td>“provides intervention and short term crisis management for children, youth and adults experiencing a mental health crisis”</td>
</tr>
<tr>
<td>Avalon Sexual Assault Centre</td>
<td>Halifax (Central Region)</td>
<td>Main: (902) 422-4240</td>
<td>“Confidential, non-judgmental and professional service… counselling services, legal support and advocacy, Sexual Assault Nurse Examiner’s (SANE) program” available for females and trans persons</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24 Hour SANE Hotline: (902) 425-0122</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Email: <a href="mailto:info@avaloncentre.ca">info@avaloncentre.ca</a></td>
<td></td>
</tr>
<tr>
<td>Antigonish Women’s Resource Centre and Sexual Assault Services Association</td>
<td>Antigonish (Northern Region)</td>
<td>(902) 863-6221</td>
<td>“Provide services to individual women and adolescent girls that include crisis and ongoing problem-solving support, information, advocacy, accompaniment and referral… direct services, programs and projects, outreach work”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mailing address: 204 Kirk Place, 219 Main Street; Antigonish, Nova Scotia; B2G 2C1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Email: <a href="mailto:info@awrcsasa.ca">info@awrcsasa.ca</a></td>
<td></td>
</tr>
<tr>
<td>Colchester Sexual Assault Centre</td>
<td>Colchester</td>
<td>(902) 897-4366</td>
<td>“Strengthening and empowering survivors of adult sexual assault (ASA) and/or child sexual abuse (CSA) who are aged 16 and over. All programs and services are equally available to all genders… services including one-on-one confidential, gender-sensitive counselling and emotional support to sexual assault and sexual abuse survivors and their family and friends”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Office Location &amp; Mailing address: 80 Glenwood Drive Truro, Nova Scotia B2N 1P3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Email: <a href="mailto:info@colchestersac.ca">info@colchestersac.ca</a></td>
<td></td>
</tr>
<tr>
<td>Head Office</td>
<td></td>
<td>1-888-470-0773</td>
<td></td>
</tr>
<tr>
<td>Victim Services</td>
<td>Dartmouth</td>
<td>(902) 424-3307</td>
<td>“Can assist you in contacting other helping agencies…. provide general information on the criminal justice system (police, courts, prosecution, corrections)”</td>
</tr>
<tr>
<td>-----------------</td>
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<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Kentville</td>
<td>1-800-565-1805</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sydney</td>
<td>1-800-565-0071</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New Glasgow</td>
<td>1-800-565-7912</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Halifax Regional Police</td>
<td>(902) 490-5300</td>
<td></td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Kentville</td>
<td>(902) 679-2567 ext. 2870</td>
<td>“Providing appropriate, accessible services to adults… through health promotion, prevention, treatment, recovery, and support for individuals and families.”</td>
</tr>
<tr>
<td></td>
<td>Middleton</td>
<td>(902) 825-4825</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cape Breton County</td>
<td>(902) 567-7730</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Colchester County</td>
<td>1-800-460-2110; ext. 45526</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cumberland County</td>
<td>(902) 667-3879</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Digby</td>
<td>(902) 245-4709</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shelburne</td>
<td>(902) 875-4200</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yarmouth</td>
<td>(902) 245-8888</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Guysborough, Antigonish and Richmond</td>
<td>(902) 867-4500; ext. 4345</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pictou County</td>
<td>(902) 755-1137</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bedford- Sackville</td>
<td>(902) 865-663</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dartmouth</td>
<td>(902) 466-1830</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Halifax</td>
<td>(902) 454-1400 or (902) 454-1440</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cole Harbour, Eastern HRM</td>
<td>(902) 434-3263</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hants</td>
<td>(902) 792-2042</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lunenburg and Queens Counties</td>
<td>(902) 543-5400</td>
<td></td>
</tr>
<tr>
<td>Survivors of Abuse Recovering</td>
<td>West Hants, Kings &amp; Annapolis Counties</td>
<td>902-679-7337</td>
<td>“community-based peer counselling service for adult survivors of childhood sexual abuse”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Toll free: 1-877-679-SOAR (7627) <a href="mailto:info@survivorseofabuserecovering.ca">info@survivorseofabuserecovering.ca</a></td>
<td></td>
</tr>
</tbody>
</table>
Appendix E
Appendix F
Survey Questions

Demographics
1. Please indicate your age:
   □ 19-29
   □ 30-39
   □ 40-49
   □ 50-59
   □ 60-69
   □ 70+

2. Which of the following best describes your gender:
   □ Male
   □ Female
   □ Prefer not to identify
   □ Other: ________________________________

3. What is your highest level of education completed?
   □ High school
   □ College
   □ Diploma in Early Childhood Education
   □ Bachelor Degree
   □ Bachelor of Education
   □ Bachelor of Social Work
   □ Masters Degree
   □ Doctorate
   □ Other: ________________________________

4. What is your primary role at the Family Resource Centre?
   □ Administrative
   □ Management
   □ Early Childhood Development and Education
   □ Family Support
   □ Other (please specify): ________________________________

5. How long have you been working at the Family Resource Centre?
   □ 1-2 years
   □ 3-5 years
   □ 6-10 years
   □ 11-15 years
   □ 16-20 years
   □ 21-25 years
   □ 26-30 years
   □ 31-35 years
   □ 35+ years

6. How would you describe the community you serve (check all that apply)?
   □ Rural
1. Did your pre-service training include any of the following topics (check all that apply):

<table>
<thead>
<tr>
<th>Topic in General</th>
<th>Topic Related to Sexual Development and Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child development</td>
<td>Children’s healthy sexual development</td>
</tr>
<tr>
<td>Child abuse</td>
<td>Children’s sexual abuse</td>
</tr>
<tr>
<td>Racial diversity</td>
<td>Racial diversity in sexuality development</td>
</tr>
<tr>
<td>Gender diversity</td>
<td>Gender diversity in sexuality development</td>
</tr>
<tr>
<td>Gender diversity (i.e., gender variation; trans, gender-non confirming)</td>
<td>Gender diversity in sexuality development</td>
</tr>
<tr>
<td>Cultural diversity</td>
<td>Cultural diversity in sexuality development</td>
</tr>
<tr>
<td>Religious diversity</td>
<td>Religious diversity in sexuality development</td>
</tr>
<tr>
<td>Ability diversity:</td>
<td>Ability diversity in sexuality development, specifically:</td>
</tr>
<tr>
<td>intellectual disability</td>
<td>intellectual disability</td>
</tr>
<tr>
<td>physical disability</td>
<td>physical disability</td>
</tr>
<tr>
<td>autism spectrum disorder</td>
<td>autism spectrum disorder</td>
</tr>
<tr>
<td>vision loss</td>
<td>vision loss</td>
</tr>
<tr>
<td>hearing loss</td>
<td>hearing loss</td>
</tr>
<tr>
<td>Sexual identity (e.g., LGBTQ (Lesbian, Gay, Bisexual, Trans, Queer), two-spirit) diversity</td>
<td>Sexual identity (e.g., LGBTQ, two-spirit) diversity in sexuality development and education</td>
</tr>
<tr>
<td>Family composition diversity (e.g., single parent, same-sex parent)</td>
<td>Family composition diversity in sexuality development</td>
</tr>
<tr>
<td>Other (please describe):</td>
<td>Other (please describe):</td>
</tr>
</tbody>
</table>
2. Since working at the Family Resource Centre, have you participated in professional development opportunities pertaining to topics such as (check all that apply):

- Children’s healthy sexual development
- Child Sexual Abuse
- Racial diversity in sexuality development and education
- Gender diversity in sexuality development and education
- Cultural diversity in sexuality development and education
- Religious diversity in sexuality development and education
- Ability diversity (e.g., intellectual disability, physical disability, autism spectrum disorder, vision loss, hearing loss) in sexuality development and education
- Sexual identity (e.g., LGBTQ) diversity in sexuality development and education
- Family composition diversity in sexuality development and education
- Language diversity in sexuality development and education
- Other (please indicate): ________________

3. In the past five years, how many professional development opportunities have you attended pertaining to children’s sexual development?

- 1
- 2
- 3
- 4
- 5 or more

4. Have there been barriers to you obtaining professional development opportunities about children’s sexual development?

- Yes (please select all that apply)
  - There are no training opportunities available to me
  - There is no financial support available for me to attend
  - I do not have time or coverage in order to attend
  - I do not have professional support in order to attend
  - Other (please specify): __________________________

- No

5. Would you like professional development about children’s developing sexuality?

- Yes (please see next question)
- No (please skip to question 7)
6. If you responded yes to question 5, which professional development opportunities would be helpful for you in order to guide families in supporting their children’s developing sexuality?

- [ ] Children’s healthy sexual development
- [ ] Child Sexual Abuse
- [ ] Racial diversity in sexuality development and education
- [ ] Gender diversity in sexuality development and education
- [ ] Cultural diversity in sexuality development and education
- [ ] Religious diversity in sexuality development and education
- [ ] Ability diversity (e.g., intellectual disability, physical disability, autism spectrum disorder, vision loss, hearing loss) in sexuality development and education
- [ ] Sexual identity (e.g., LGBTQ, two-spirit) diversity in sexuality development and education
- [ ] Family composition diversity in sexuality development and education
- [ ] Language diversity in sexuality development and education
- [ ] Other (please indicate): _______________________________
Supporting Families

1. Within your current capacity, what kinds of support do you offer to families of young children (i.e., birth to school entry) in order to build their capacity in supporting their children’s healthy sexual development, and respond to the following questions:

<table>
<thead>
<tr>
<th>Materials &amp; Resources Used</th>
<th>What are some examples?</th>
<th>Do you feel they reflect diversity in (check all that apply):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Support</td>
<td></td>
<td>Do you feel that you are able to adequately reflect diversity in:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Race</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Culture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ability</td>
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<td></td>
<td></td>
<td>Sexual identity</td>
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<tr>
<td></td>
<td></td>
<td>Family composition</td>
</tr>
<tr>
<td>Workshops</td>
<td></td>
<td>Race</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Culture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sexual identity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family composition</td>
</tr>
<tr>
<td>Brochures and Pamphlets</td>
<td></td>
<td>Race</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Culture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sexual identity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family composition</td>
</tr>
<tr>
<td>Books</td>
<td></td>
<td>Race</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Culture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sexual identity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family composition</td>
</tr>
</tbody>
</table>

Please feel free to elaborate on any of the above information shared:
2. Within your current capacity, what kinds of support do you offer directly to young children (i.e., birth to school entry) in order to support their healthy sexual development, and respond to the following questions:

| Materials & Resources Used | What are some examples? | Do you feel they reflect diversity in (check all that apply):
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Support</td>
<td></td>
<td>□ Race □ Gender □ Culture □ Religion □ Ability □ Age □ Sexual identity (e.g., LGBTQ, two-spirit) □ Family composition □ Language</td>
</tr>
<tr>
<td>Toys or Games</td>
<td></td>
<td>□ Race □ Gender □ Culture □ Religion □ Ability □ Age □ Sexual identity (e.g., LGBTQ, two-spirit) □ Family composition □ Language</td>
</tr>
<tr>
<td>Books, Brochures, and/or Pamphlets</td>
<td></td>
<td>□ Race □ Gender □ Culture □ Religion □ Ability □ Age □ Sexual identity (e.g., LGBTQ, two-spirit) □ Family composition □ Language</td>
</tr>
<tr>
<td>DVDs/Movies</td>
<td></td>
<td>Do you feel that you are able to adequately reflect diversity in: □ Race □ Gender □ Culture □ Religion □ Ability □ Age □ Sexual identity (e.g., LGBTQ, two-spirit) □ Family composition □ Language</td>
</tr>
</tbody>
</table>

Please feel free to elaborate on any of the above information shared:
3. In your experience, how frequently are families beginning to seek information about healthy sexuality for their young children at the following ages:

<table>
<thead>
<tr>
<th>Age of Child(ren)</th>
<th>How Frequently (please circle one for each age)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>Never</td>
</tr>
<tr>
<td>12-24 months</td>
<td>Never</td>
</tr>
<tr>
<td>2 years</td>
<td>Never</td>
</tr>
<tr>
<td>3 years</td>
<td>Never</td>
</tr>
<tr>
<td>4 years</td>
<td>Never</td>
</tr>
<tr>
<td>5 years</td>
<td>Never</td>
</tr>
<tr>
<td>6 years</td>
<td>Never</td>
</tr>
</tbody>
</table>

4. Within your role, how often do you:

<table>
<thead>
<tr>
<th>1. Include children’s sexual development in your programming?</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Is your choice to (not) include children’s sexual development in your programming impacted by the policies of your family resource centre?</td>
<td>No</td>
<td>Yes (please explain):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Wait for families to ask about sexual development?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Usually</td>
</tr>
<tr>
<td>4. Avoid the topic of children’s sexual development?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Usually</td>
</tr>
</tbody>
</table>

5. If you have ever struggled with the topic of children’s sexual development when supporting families, can you please share the reasons why (Check all that apply)?

- [ ] I do not have adequate knowledge on the topic
- [ ] I feel that I have other topics that need to be prioritized
- [ ] I do not have adequate materials to support families
- [ ] I do not want to offend families
- [ ] Families do not ask for this information
- [ ] I work with families who have children who are too young to benefit from this information
- [ ] I feel embarrassed about the topic of sexual development
- [ ] It is outside of my scope of practice
- [ ] I do not want to give families inaccurate information
☐ I do not feel supported by my administration to offer this type of support
☐ Other (please explain): ______________________________
6. Please respond to the following questions, based on your experience supporting families with children in the early years (birth to school entry):

<table>
<thead>
<tr>
<th></th>
<th>In your experience, how often have families looked for information on this topic (Please circle)?</th>
<th>On a scale of 1-5, with 1 being “very uncomfortable” and 5 being “very comfortable”, how comfortable do you feel providing support for families with this topic?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Privacy</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Consent</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Self-Pleasure, Masturbation</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Gender</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Sexual Identity (e.g., LGBTQ, two-spirit)</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Relationships</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Procreation (where babies come from)</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Child birth</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Sexual intercourse</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Sexual acts</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Naming body parts</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Protective methods (e.g., condoms, birth control)</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Media’s impact on sexuality</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Hypersexualization (e.g., having sexuality imposed-often by media)</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Sexually Transmitted Infections (STIs)</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Sexual abuse prevention</td>
<td>Often Sometimes Rarely Never</td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>
Concerns about their child having experienced sexual abuse | Often Sometimes Rarely Never | 1 2 3 4
---|---|---
1 5

Sexual behaviours demonstrated by their children | Often Sometimes Rarely Never | 1 2 3 4
---|---|---
1 5

Please include any topics that you feel were missed, that families have asked you for support with:

7. When the decision has been made that extra support is required in order to support families with the provision of sexuality education to their young children, to whom have you referred families? (please check all that apply)

- Psychologist
- Paediatrician
- Early Childhood Educator
- Sexual Health Centre
- Elementary School personnel (either during primary transition or through consultation)
- Occupational Therapist
- Youth Project
- Early Interventionist
- Mental Health Agency
- EIBI (Early Intensive Behavioural Intervention Program)
- APSEA (Atlantic Province Special Education Authority)
- Family Physician
- Public Health Agency
- Other (please identify): ____________________________

8. Are there any challenges with accessing these supports?

- No
- Yes (please explain): __________________________________________________________
  __________________________________________________________
  __________________________________________________________
  __________________________________________________________

9. What other challenges have you encountered in supporting children and their families in regards to children’s healthy sexual development?
Because all responses are obtained anonymously, please note that once you click “submit”, your answers cannot be withdrawn from the research.
Should you have any further questions or concerns regarding this study, please contact either Emily Martinello at (Emily.Martinello@msvu.ca) or the supervisor, Dr. Devi Mucina at (Devi.Mucina@msvu.ca). If you have questions about how this study is being conducted and wish to speak to someone who is not directly involved in the study, you may contact the Chair of the University Research Ethics Board c/o MSVU Research and International Office at 457-6350 or via e-mail at research@msvu.ca.
Thank you for taking the time to complete this survey to better understand how family resource centres are supporting children’s healthy sexual development in the early years.