THE DEVELOPMENT OF A COMPREHENSIVE PROGRAM IN HIGHER EDUCATION FOR SCHOOL HEALTH EDUCATORS

DISSERTATION

Presented to the Graduate Council of the North Texas State University in Partial Fulfillment of the Requirements

For the Degree of

DOCTOR OF EDUCATION

By

Joseph Taylor Miller, B. S. E., M. A. T.
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The problem of this study was the development of a comprehensive health education program in higher education for the preparation of public school health educators. The purposes were fivefold: (1) to conduct a survey of the historical nature and significance of the concept of health education in higher education within the United States; (2) to conduct a survey of the major health needs in the United States; (3) to survey the degree of attention given to curriculum areas in current bachelor degree programs of health education in the United States; (4) to develop the criteria for a comprehensive program of health education in higher education; and (5) to develop a comprehensive program of health education in higher education.

Research techniques utilized included an in-depth examination and study of the professional literature written on the history of health education in higher education within the United States. This investigation included comparisons and contrasts of health education programs in higher education during the various historical time periods. The investigation also included a review of the various research inquiries done by educators trying to determine the status
of health education programs. A review of the professional literature was conducted to determine the major health needs or problem areas in the United States. These health need areas became the major health curriculum areas for the undergraduate professional preparation curriculum developed in Chapter V of the study.

A questionnaire was developed to survey the degree of attention given to curriculum areas in current bachelor degree programs of school health education in the United States. The persons receiving the questionnaire were directors of the undergraduate health education programs at their particular institution of higher education. Illustrations were then set up so that the results could be easily read and understood.

After all of the research had been completed, the data gathered were analyzed; and the development of the criteria for, and the comprehensive program of health education in higher education was developed. The proposed comprehensive health education program presented in this study developed the concept that the thrust of health education should be directed toward the development of a positive mental and emotional health concept within the individual. Within the program each course relates to the concept of positive mental and emotional health.

When the study had been completed, the following recommendations were presented:
1. The department housing the undergraduate degree program in health education should be in a separate health education division or health science department.

2. The degree awarded to graduates should be a specific health education or health science degree rather than several other types of degrees.

3. The faculty who teach in the professional preparation programs should hold health science or health education degrees or be retrained in the health areas within five years from the date set down by the state certification boards of each state.

4. The proposed curriculum model should be implemented in one or two institutions offering professional preparation for public school health education programs on the bachelor level.

5. During the implementation or trial period, the courses of study should be continually updated and evaluated to determine their correctness and effectiveness in material presented.

6. Further study should be done to determine if a competency-based program could be implemented using the developed curriculum model.
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CHAPTER I
INTRODUCTION

The world is changing rapidly, and with this change man is encountering health problems of an ever increasing volume. Allen and Holyoak make reference to this extensive change when they contend that

... in recent years our society's health problems have reached staggering proportions. Problems such as drug abuse, water and air pollution, sex education and increasing psychological disorders have been compounded by massive civil disturbance, crime, poverty and the threat of over population. These and many other difficulties confront the health educator as he seeks more effective instructional methods with which to provide students the necessary knowledge to make intelligent decisions regarding their health behaviors (3, p. 118).

Nyquist substantiates this contention by stating that people must recognize that drug addiction, alcoholism, malnutrition, lung cancer, venereal disease, and emphysema are not completely medical failures, but educational failures. The failure to recognize that health education programs must be initiated before there is a full-fledged epidemic in our midst has led to frightening increases in preventable diseases (13, p. 36).

One dimension of the total issue relates to the abuse of alcohol:

The abuse of this drug denotes one of the biggest health and social problems in the United States
today. It is estimated that there are nine or ten million persons whose drinking is associated with serious problems, including about seven million who are alcoholics. . . . alcohol use is often associated with crime, poverty, and other social problems. Alcohol also contributes to physical illness, mental illness, and family conflicts (15, p. 153).

Stephen Bender offers another dimension of the total issue in question when he discusses the problem of venereal disease. Bender states that

. . . venereal disease, more specifically syphilis and gonorrhea, can truly be considered a major problem among American teenagers. Conservative estimates purport that some 2,000 teenagers a day are infected with syphilis or gonorrhea, and perhaps even more startling is the fact that over half of all the venereal disease infections in a given year are contracted by boys and girls under twenty. In fact, venereal disease accounts for nearly half of all the reportable communicable diseases in the adults. While the incidence of syphilis, the more serious of the two common venereal diseases, has been declining for the past several years, gonorrhea on the other hand has been steadily on the increase. One could expect that there is roughly ten times as much gonorrhea as syphilis in a given community and gonorrhea has now reached epidemic proportions in some areas (5, p. 105).

A third dimension of the issue relates to mental and emotional health. Hickman makes reference to the vastness of the problem when he states that "approximately half of the hospital beds (750,000) in the United States are occupied with mental patients, and many thousands of others need hospital treatment" (10, p. 92). The National Committee Against Mental Illness further illustrates this contention by emphasizing that "more hospital beds are
occupied by mentally ill patients than by patients with all other illnesses combined" (9, p. 27).

Abrams, et al., demonstrate the seriousness of the problem by establishing the fact that "the need for psychiatric services in grade schools and high schools has grown faster than private medical service and public clinic psychiatric service can possibly meet. This is generally true across the nation" (2, p. 138).

The mental illness dilemma is not only born out by its statistics in numbers of patients occupying beds in our nation's hospitals, but has been cited as one of the most common problems among the college and university age population. Evans and Warren state that "mental illness is no respector of age; it can afflict anyone. Among college students in a large university, for example, psychiatric conditions were found to be one of the ten most common problems diagnosed in the clinic and infirmary" (8, p. 28).

Hein, et al., contend that "suicide is the second most common death among college students and . . . the rate for college students is about one and one-half times that of non-college students of the same age" (9, p. 27).

Statement of the Problem

The problem was the development of a comprehensive program in higher education for the preparation of public school health educators.
Purposes of the Study

1. To conduct a survey of the historical nature and significance of the concept of health education in higher education within the United States.

2. To conduct a survey of the major health needs in the United States.

3. To survey the degree of attention given to curriculum areas in current bachelor degree programs of health education in the United States.

4. To develop the criteria for a comprehensive program of health education in higher education.

5. To develop a comprehensive program of health education in higher education.

Guideline Questions

Certain guideline questions were formulated: 1. What was meant by the term health education? 2. What conceptual differences, if any, existed among health educators in the nature and significance of health education in regard to higher education? 3. What modifications occurred in the historical nature and significance of health education in higher education in the United States? 4. What major health needs exist in the United States? 5. What degree of attention do current programs in higher education for health educators give to the current health needs?
Definition of Terms

1. **Higher education** refers to any formal educational program that is continued after high school in a four year college or university.

2. **Health education** is a process with intellectual, psychological, and social dimensions relating to activities which increase the abilities of people to make informed decisions affecting their personal, family, and community well-being. This process, based on scientific principles, facilitates learning and behavioral changes in both personnel and consumers, including children and youth (14, p. 103).

3. **School health educator** refers to an individual with professional preparation in health education or health science who is qualified for certification as a health teacher and for participation in the development, improvement, and coordination of school and community health education programs (14, p. 103).

4. **Health needs** refers to those needs which affect the quality of one's physical, mental, and emotional well-being and which enable one to live effectively.

5. **Hygiene** refers to instruction in simple, functional matters relative to the preservation of health practices and conditions.

6. **Values clarification** refers to a learning experience that allows a student to freely choose from alternatives,
prize his choice, and act repeatedly on his choice in some pattern of life.

Background and Significance

The review of literature tended to indicate that our society's health problems have reached epidemic proportions and are increasing at a faster pace than society can cope with. The literature also seemed to indicate that the nature and significance of a comprehensive program in higher education for health educators appeared uncertain and undefined.

In 1952, a study was conducted in Minnesota pertaining to the preparation of health teachers. Using fifty-five teacher training institutions, the researchers concluded that teachers were not well qualified and that this should serve as a stimulus to teacher training institutions to examine the professional preparation curricula (7).

Forrest E. Conner also makes reference to the inadequacy of the professional preparation of public school health education teachers when he states,

It [health education] is taught by a teacher with inadequate or no preparation in health education and who often lacks the skill or interest for proper health teaching; and little attention is paid to sequence of content areas. Too often this results in a lack of consideration and understanding of the importance of protection and promotion of health as a total entity—physical, mental, and social (6, p. 4).

Mackey and Nelson add additional emphasis to the contention that curriculum development and teacher preparation
in health education has been substandard. They contend the following:

Traditionally, the curriculum development in health education has taken a back seat to other subject areas in the public schools. Health education has been included in many school curricula as a substitute for or in conjunction with physical education, or has been wedged into an over-crowded biology or home economics class. If it has been given the stature of a separate course it has, in too many instances, been taught as an anatomy or physiology course. Health educators have tended to rely on lecture, scare tactics, textbooks and memorization of data. In general, health education has been the victim of neglect, omission, duplication, and poor instruction (12, p. 575).

The simple fact that health and people problems are on the increase in the United States seems to imply that the professional preparation programs in the institutions of higher education are turning out unsatisfactory health teachers for the public schools.

In the fall of 1961, the nationwide School Health Education Study was begun. The study when completed revealed glaring deficiencies and weaknesses in health education programs in the nation's schools. One of the major reasons for these deficiencies and weaknesses was an inadequate preparation of teachers who will be expected to assume responsibility for health instruction in the public schools (14).

The American Association of School Administrators has stated in no uncertain terms that one of the imperatives of a good school health program is "a comprehensive program of
health instruction with selective and sequential development of health concepts at all grade levels, K to 12" (6, p. 1). In order to satisfy these demands, the present professional preparation programs in health education in higher education must change from a mere program of individual courses dealing with health needs of curriculum areas to a more unified and integrated curricula. If this concept is carried out, a better qualified health educator for the public schools could emerge.

In 1971, the American Association for Health, Physical Education and Recreation's Board of Directors directed an already approved committee to proceed with a National Conference on undergraduate professional preparation in Health Education. In 1972, the work was completed and in 1974, the findings were published. Some of the results of this study advocated that

(1) Curriculum development is a dynamic, ongoing process and justifies the need for periodic evaluation and restructuring of the health education curriculum for prospective teachers.
(2) Existing curriculums must incorporate recognized innovative and creative ideas of design into existing curricula.
(3) Existing curriculums must develop content into a meaningful course of study and must integrate content areas with common conceptual threads as they focus on the central problems of the life cycle of man (1, p. 120).

The findings of the 1974 AAHPER study are in congruence with the School Health Education Study completed in 1961. Both studies advocated and recommended that the professional
preparation curriculums in health education be upgraded and that the curriculum content be integrated into a conceptual approach. The essence of this contention, based on the facts presented herein, is that the development of a curriculum in professional preparation of health educators for the public schools will begin to alleviate the many health problems plaguing our society. Richard R. Lussier affirms this premise when he states,

... educators at all levels are failing to provide for student health education needs and are therefore turning students into the society who are not able or prepared to resolve the health problems generated by our contemporary life style (11, p. 620).

In regard to the inadequacy of health education curriculums, Roger F. Aubrey states that the weaknesses of public school health programs are caused by the following factors:

(1) Inadequate training of teachers during college preparation.
(2) A failure of colleges to stress the importance and worth of this area.
(3) A failure of colleges to introduce future teachers to useful materials, units, lessons, and concepts in health education.
(4) The failure of colleges to train teachers in principles of group dynamics, attitude formation, and value clarification (4, p. 285).

Aubrey also makes reference to the contention that a more unified and integrated professional preparation program in health education is needed. He contends that

the thrust of health education should change from a focus on matters of physical fitness, nutrition, safety, anatomy, disease control, and the like to a broad process of personal development and mental health. Within this broad area the previous subjects could be covered but the emphasis should
be the emerging and evolving personality of the student (4, p. 286).

The concept indicated in Aubrey's statement seems to point toward a basis upon which a comprehensive professional preparation program for public school health educators could be established.

In analyzing the review of the literature stated herein, it can be concluded that a study of the need for a comprehensive program in higher education for health educators appears to be required.

**Methods and Procedures**

An in-depth examination and study of the professional literature served as a basis upon which an historical development of the nature and significance of the concept of health education in higher education was formulated. Emphasis was placed on the evolution of health education primarily as an outgrowth of personal concerns with the health of school children from 1800 to the present. This investigation included comparisons and contrasts of health education programs in men's and women's colleges as well as co-educational colleges during the various historical time periods. The investigation also included a review of the various research inquiries done by educators trying to determine the status of health education programs.

A review of the professional literature was conducted to determine the major health needs or problem areas in the
United States. These health need areas became the major health curriculum areas for the undergraduate professional preparation curriculum developed in Chapter V of this study.

The health curriculum areas were listed into priorities ranging from the most important to that of least importance, as determined by the National Center for Health Statistics of the United States and this writer. The development of this facet of the study came from an empirical examination and an in-depth study of the literature.

A questionnaire was developed to survey the degree of attention given to curriculum areas in current bachelor degree programs of school health education in the United States. The questionnaire used in the survey was examined by a jury of seven experts in the field of health education prior to its being formally distributed throughout the United States. Each item in the questionnaire was examined and determined valid when four of the seven experts agreed on the question. The items on the questionnaire were formulated out of the investigation and examination of the historical development of health education in higher education in the United States. A cover letter and format was agreed upon and the questionnaire was distributed to seventy-six colleges and universities throughout the continental United States offering an undergraduate degree in health science or health education. The persons receiving the questionnaire were directors or the chairman of the undergraduate health
education programs at their particular institution of higher education. A follow-up questionnaire and letter was mailed within three weeks after the original survey, and a cut-off reply date was established. The total time for the completion of data return was three months. The list of colleges was derived from the 1974 Eta Sigma Gamma, professional health education honorary society listings, and the United States Department of Health, Education and Welfare's Health Resources Statistics, Health Manpower and Health Facilities, 1971 report.

Based upon the findings established in the historical survey of literature, the survey of the major health needs or curriculum areas in the United States, and the questionnaire survey to determine the degree of attention given to curriculum areas to current bachelor degree programs of health education in the United States, the development of the criteria for, and a comprehensive program of, health education in higher education was developed.
CHAPTER BIBLIOGRAPHY


CHAPTER II

A SURVEY OF THE HISTORY OF HEALTH EDUCATION IN HIGHER EDUCATION WITHIN THE UNITED STATES

History of Health Education in Men's Colleges from 1800 to 1880

As America in its beginning was a frontier to be discovered, so were the ideals of health education. In the past, the development of professional preparation in health education in the United States was related to the development of teacher education and public health education. The evidence tends to indicate that health education began primarily from an outgrowth of personal concerns with the health of school children.

Horace Mann was one of the first educators who felt the need to include personal hygiene information in teacher preparation programs. Mann stated that "no person is qualified to have the care of children for a single day who is ignorant of the leading principles of physiology" (12, p. 34). This is the beginning of an effort to improve the health of children for health education by appealing to public school boards for recognition of a course for children in physiology and hygiene (12). The appeal made by these scholarly men perhaps enhanced the concept that the
professional preparation of public school teachers in health education should be instituted in higher education.

As early as 1818, Harvard's school of men offered a program of health education. This program did not contain specific classes, but related health to the college senior through lectures on anatomy and hygiene. "Perserving health and prolonging life" (12, p. 36) was also discussed in the Harvard lectures. This program was initiated by a professor of physics.

There are important factors in these first health lectures that should be discussed. First, the program was offered only to seniors. This practice was followed until the middle 1800's. Second, the terms physiology and hygiene were established as the core terms of health education for this period. Third, the persons teaching the classes were associated directly with medieval health. These men were usually physicians or physics instructors in the colleges whose primary teaching sources were the theories that they held and a book on natural theology by Paley (12, p. 37).

From Harvard, health education moved to Amherst Men's College. At Amherst, located in Amherst, Massachusetts, health advanced in so many areas that it is considered the foremost pioneering college in early health education. In 1823, Amherst's program was, as was Harvard's, offered only to seniors. General health instruction, physical culture, laws of life and health were added to the curriculum of
anatomy and physiology and hygiene. Also, in this same year, requirements were established for teaching personnel. These requirements were "1) Professor--educated physician, 2) give instruction in gymnastics, 3) give instruction in health" (16, p 37). All these advances in health education culminated into the first department of Physical Education and Hygiene.

Many times in the 1800's schools would start a program and in a few years stop health education. Amherst College, however, continued moving toward a more progressive program in health education. Amherst was the first institution to employ a physician for the expressed purpose of directing the health activities of schools. Professor Hooker, the first health educator employed at Amherst, started a program for entering freshmen at Amherst teaching them the laws of health (12).

It is well known today that if a school administration does not stand behind an idea, that idea will not be explored. At Amherst, the administration did recognize and work for advances in health. In 1853, Edward Hitchcock, M. D., was appointed head of the new physical education and hygiene department by President William A. Sterns of Amherst. President Sterns accordingly expressed the purpose of health education in higher education perhaps for the first time in the 1800's. "Students of our college have bodies which need care and culture as well as the intellectual and moral
powers, and which need this care at the same time with higher education" (16, p. 37). Amherst's health program included classes in lab work, student medical exams, exercise programs, medical treatment, and annual reports on students' health. Dr. Hitchcock was the principal teacher, along with Hooker, at Amherst. Their main source of material in the later 1880's was a book by Hitchcock on anatomy and physiology.

Amherst College influenced other institutions remarkably, but the next stage of history is disappointing in contrast with the great strides made in the early years of health education at Amherst. It is rather puzzling, as one looks back over the years, to understand why other institutions of higher education seemingly failed to incorporate and support a program for the health of their students. Dr. Joseph Raycroft contended that there was a tendency on the part of the trustees and faculties of colleges of men to regard any source or attention to the physical welfare of the individual as unacademic, and for some esoteric reason, unworthy of association with intellectual activities and training (16). Those colleges of this period, however, that did provide health education can also be given credit for developing the foundations for health education in higher education.

In 1851, at the College of the City of New York, instruction was given in anatomy, physiology, and hygiene.
These were planned with "reference to the active duties of operative life" (12, p. 64). Tufts College, located in Medford, Massachusetts, also presented to its students a program similar to New York City College. Dr. Oliver Dean, President of Tufts College, instituted the program. However in 1856, a clergyman was named president at Tufts College, and he discontinued the health education program (12).

In 1860, Williams College of Williamstown, Massachusetts, divided its health curriculum into freshman and senior years. The president of the college, Mark Hopkins, M. D., taught the classes himself. The freshman courses included health habits, diet, and exercise. In the senior courses, six weeks of anatomy and physiology were taught. President Hopkins used a text entitled Combes on Health and Mental Education as a teaching source (12, p. 63). Other schools of this period that started to incorporate health were Yale, Bowdoin, Cornell, Oberlin, Pennsylvania, Michigan, Brown, Wisconsin, Stanford, and Chicago (12, p. 65).

The era of 1800 to 1880 can be summarized as the foundation of health education in higher education. Without the organization and administrative work of Amherst, Harvard, and Williams colleges, health education might still be just an idea without exploration. "It was speculated that in 1850, there were only six schools with health education programs. In the year 1884, 61 per cent of the forty-six
recognized men's colleges had some health education classes" (12, p. 64). Health education was gaining recognition and would continue to do so throughout the period of 1880 to 1900.

History of Health Education in Men's Colleges from 1880 to 1900

During the next twenty years (1880-1900), physical education and hygiene departments in higher education were established in close to thirty additional institutions in America. In these institutions, a large proportion of the instructors and department heads in health education were holders of M. D. degrees. "These physicians placed more emphasis on anthropometry, body symmetry, strength tests, and formal exercises" (16, p. 39).

During this era, another addition to the health education program was the uniting of the student health service to the instructional program. The connecting link was the physician who administered to the medical needs, as well as the instructional needs of the students.

Possibly the most important development in the period of 1880 to 1900 concerning curricula was the state laws for education and those affecting education. The most prominent ones were the temperance laws. Each school had to teach anatomy and hygiene with an emphasis on alcohol and narcotics. Thirty-eight states passed this type of legislation. James Frederick Rogers clarified this point when he stated that
"no wave of legislation having to do with school hygiene and sanitation has swept the country as that of the temperance movement" (12, p. 51). Other than the legislation provoked by the women's temperance movement, the curriculum remained the same. The student was provided courses in hygiene, physiology, and anatomy with the addition of the areas of health inspection and supervision.

History of Health Education in Men's Colleges from 1900 to 1940

The period from 1900-1940 seemed to be a strategic era as far as modern health education was concerned. Stemming from the protests against the previously employed methods, and from the appeals for school health generally, a philosophy based upon health behavior as the final determinant of learning came into being (16, p. 81). Habit formation was a definite trend and is shown by the following: "... it appears to be the present tendency to center hygiene instruction not upon the physiology, but upon training the student in habits which fit him to live efficiently and happily..." (14, p. 81).

At the turn of the twentieth century, many authors were beginning to express the opinion that health education should be required in the program of study for all students before leaving college. Story, for example, insisted that "... the graduate without health is a graduate with a limited efficiency" (14, p. 103). Health education was beginning
to be looked upon as the basic responsibility of every institution. Wood seemed to sum up this contention quite well when he stated that

there should be primarily some form of instruction and motivation to insure in college and university students a high percentage of practice and accomplishments in the habits, attitudes, and knowledge of physical, mental, social hygiene, or stated in other words, matters relating to health of the organism, of personality and of home and community (22, p. 31).

Several surveys began appearing questioning health education and health practices in the early twentieth century. At the beginning of this century, George L. Meylan conducted a survey to determine the status of health programs in the colleges and universities. A summary of his study was reported as follows:

1. 32 institutions—84% offer courses in hygiene
2. 67% offer one course—33% offer two to six
3. 75% of institutions require the courses
4. 52% have freshman classes only
5. 78% of the colleges offer hygiene in the physical education department
6. Gym directors give hygiene courses in 75% of schools (62% of gym directors have professional rank) (14, p. 104).

Meylan’s study pointed out that a very limited program of health education existed in the colleges and universities. His study suggested that this limited program was specifically a limited hygiene education program rather than a general health education curriculum.

In 1910, the Committee on the Status of Instruction in Hygiene in American Educational Institutions, with George Meylan as the chairman, conducted another survey which gave
an insight into the future directions of health education. Out of 124 major colleges and universities, 90 per cent responded. The significant facts from this study were that (1) directors of physical education were assuming the responsibility of hygiene instruction from medical or college physicians; (2) hygiene was being offered to a more diverse group of college students than before; (3) sixty-three percent of the reported schools started their health education program after 1900; and (4) the standard hygiene course was being removed in favor of a more general approach to health.

In 1910, the content of the courses became more varied; yet temperance classes in alcohol, drugs, and tobacco were still a dominant theme in health education. However, probably the most significant change was the incorporation into the curriculum of courses in "sex hygiene" for family health. In addition, as cures for communicable diseases were being discovered, they too influenced health program instruction.

One other department that helped the development of health education in this period was the extension division of the colleges. For example, at Columbia College, the extension department conducted most of the health classes for the students. In 1916-17, Columbia offered forty-nine of 470 extension courses in community or personal health (12, p. 144). This was a beginning toward more active participation by colleges into community health education.
As the curriculum was reconstructed, so the terminology was altered. The term "health" was introduced by the Child's Health Organization for the old term "hygiene." Because of the misconceptions of the term hygiene, colleges, secondary, and elementary schools readily accepted the term health over hygiene. Hygiene was a word of the past, and the term health had meaning for the future.

Yale and Stanford Universities made a mark in health education in 1920 by citing a need for mental hygiene courses and setting up such a course. Stanford also established a first in health education by offering a degree program in health. The recognition given by Stanford to health served as an impetus to other colleges to construct degree programs.

In 1931, Kirkpatrick of Columbia University published the course content of his college. The topics are similar to those taught today. The curriculum included (1) judgments covering the personal and public requirements of home and community, (2) health care, (3) communicable disease, (4) health and medical advisors, (5) drugs and alcohol, (6) safety, (7) emergency procedures for accidents, and (8) lawful health practices (9, pp. 47-48). Thus, as colleges began to teach more areas of interest in health, the question was raised as to whether the causes were being eliminated as they were learned.
Kilender, of Panzer College, New Jersey, conducted a survey within his college in 1934 to learn the extent of the health knowledge of the college students. His findings are as follows:

1. students have a fair knowledge of general health, but a poor knowledge of specifics
2. law of the practice of health habits—an important addition to this period of health education history
3. women's knowledge was better than it was in the past
4. seniors were no more knowledgeable than freshmen
5. health topics that knowledge was the lowest in were ranked
   a) nutrition
   b) education for parenthood
   c) mental health
   d) temperance
   e) first aid
   f) elimination of wastes
   g) sleep and rest (3, p. 46).

An important point can be made from Kilander's survey. No matter how varied the curriculum becomes, no matter how many years it functions, if the concepts learned are not practiced, it becomes of no value.

Even though health education progressed rapidly from the early 1800's until the 1930's, the primary purpose was instruction. The goal of behavior change evidently was not being achieved. For example, during the induction of men into the armed forces of World War I, a high percentage were refused induction for health reasons. It would seem that from past experience the emphasis on what health education would have to accomplish in the next decade was established: "... stimulation, development, and extensive instruction
and training in hygiene in normal schools, colleges, and universities" (12, p. 226). Thus, it seems that the presentation of facts without value clarification on the part of the student and/or prospective teacher is a possible waste of time.

History of Health Education from 1940 Until the Present

The modern concept of health education is changing, and with this rapid change, the health educator must be prepared to meet the challenge in the classroom.

Our modern concept of health has undergone great transformation. From the curing of disease, it has grown to encompass a broad constructive program. The health educator has joined forces with the university physicians, the deans, the administration, and others in promoting health—mental, emotional, physical, social. The modern concept of health education recognized the opportunities for health education that permeate many activities and causes (10, p. 18).

The modern objective of health education is not the mere presentation of facts. Historically, it has been shown that knowledge does not necessarily guarantee changed health attitudes and health behavior. The concept of health education is changing from subject material to learner. To be effective, health education must motivate the individual to modify living habits advantageously in light of new knowledge and new resources. Formally, the main emphasis was given to the presentation of factual information, particularly to the study of anatomy and physiology, which had no effect in creating desirable health attitudes and intelligent health behavior, both of which are basic to optimal health (10, pp. 13-19).

It is evident that educators from 1940 until now were mainly interested in constructing the health education program for
the practical usage by the students. Course content did not change as far as topics, but it changed in philosophy of how to teach. Today students participate in identifying health problems, interests, and needs. The health content is then organized in light of accumulated data to meet the needs and interests of the particular students in each class. In 1949, Columbia University instituted a course in "Personal Living." It was required of all freshman students. The essential aim of the course was to help the student adjust to the real life problems imposed by the new challenge of college and adult life. The course consisted of the following elements: (1) problems of emotional adjustment, (2) problems of motivations and goals, (3) problems of social adjustment, (4) problems of home relationships, (5) problems associated with scholastic situations, (6) problems associated with defective health habits, (7) problems of sexual adjustment, and (8) problems of economic adjustment (20, p. 21). Columbia was not alone in its quest of adapting the curriculum to the student; it is just one example of the modern trend of the 1940's onward.

More trends of health education were developed: (1) unification of health and physical education into the department of health and physical education, and (2) the elimination of physicians as instructors in health. "In 1948, the number of health educators holding an M. D. degree dropped to 23 per cent while the number of institutions
offering health education increased" (10, p. 20). The president of the American Health Association stated, "You are quite right that health education is being taken over by nonmedical groups and for two reasons: fewer and fewer physicians want to devote time to health education, and the educated group does not believe that men with only medical training are qualified to teach" (10, p. 36). Third, health education, while being dislocated from physicians, was also being removed from student health services. Fourth, modern health terms have been accepted. Terms such as physiology and anatomy were discarded and changed to meet the needs of the students and were named accordingly, i.e., community health, sexual development, etc.

Probably the most comprehensive study ever completed on the scope and caliber of health services in American colleges and universities was that compiled in 1953 by Moore and Summerskill. Sixty-one per cent of the 1,157 colleges were polled. Three key points summarized the findings. First, courses in health are offered in 80 per cent of colleges with student health services. Fifty per cent require these courses. Second, nine out of ten colleges with health education programs instruct on both physical and mental health. Third, health education is supervised by the health service staff in less than four of ten colleges (14, p. 15).

Another survey conducted by the National Conference on College Health Education in 1955 reported as follows:
(1) out of 442 colleges polled, 358 offered health, (2) the course was given by the Physical Education Department in 133 institutions, a health educator in 149, a biologist in 68, a physician in 27, and a nurse in 27 (14).

A basic philosophy of health education was developed by Smolensky and Bonvechio in 1966. Their principles were stated as follows:

1) school is the most logical social institution for disseminating health information; 2) health includes the physical, mental, emotional, social and moral aspects of the human organism; 3) health is not an end in itself; it is just a means for a more productive life; 4) the immediate and long range goal of health instruction should be the intelligent self direction of one's own health behavior and of his community; 5) an instructor does not "teach health" but he rather teaches for health; 6) health determines one's ability to function efficiently; 7) health is more than just being free from disease; 8) total health implies that one must be healthy physically, mentally, emotionally, socially, and morally; 9) health is a relative and dynamic thing--it is extremely difficult to define adequately--it fluctuates up and down the scale of life, which implies that one is at different levels of health throughout every day and every hour of life; 10) one of the most important responsibilities of the school is to health educate each and every individual to the place where he or she can intelligently direct his or her own health behavior as a responsible citizen; 11) health education is a collective discipline which draws upon medicine, the sciences, anthropology, sociology and psychology; but it is the only discipline which uniquely and specifically synthesizes the findings of these fields into implications for health; 12) interaction of his heredity and environment. For school health education, the modern period 1940 through the 1960's was one of mobilization, restructuring and building upon its foundations established by previous developments (12, p. 382).

Smolensky and Bonvechio seem to point toward a now emerging philosophy of clarification for the student. Their
principles also lead to an educational philosophy that develops a theory of relationship, thus, health areas.

History of Health Education in Women's Colleges

Most of the early colleges for women included instruction in physiology and hygiene. The reason for acceptability of the program was that the men who founded the first women's colleges took a broader and more realistic view of education, "inasmuch as they regarded it as a discipline of body, mind, and emotions which provide a sound basis for successful living" (12, p. 38). Undoubtedly, this was due in part to the fact that they were not so concerned with professional curriculum such as law, medicine, and preparation for the clergy as were men's colleges.

"Hygiene and physiology were termed as cornerstones to the curriculum of women's schools such as Holyoke, Smith, Wellesley, and Vassar" (12, p. 37). Holyoke's program developed a course for freshmen in college in hygiene and physiology in 1837. One leader in women's education became well known in this period for her work in gymnastics and physical education. Catherine Beeder, from Hartford Female Seminary, was known as the first woman physical educator. In 1865 and 1875, Vassar and Wellesley instituted their programs of health study. These programs were, from the earliest days, positive programs for the promotion of health and well-being, consisting of instruction in physiology,
anatomy, and hygiene, together with daily periods of formal exercises. The programs were organized by physicians on the college staff who wrote the objectives of the course and dealt with the students individually.

In 1897, Smith and Bryn Mawr Colleges, and the Women's College of Baltimore had physicians in residence. The physician, as in men's colleges, had to do medical work as well as instructional work. He also maintained the gymnasium for exercise programs.

In 1889, the general assembly of the state of Georgia established a college for the education of white girls. Sixteen years later a health service program was started by Kathleen Wood. The program was noted for its comprehensiveness, philosophy, and methods (12, p. 145). Other than the usual courses appearing at this period of time, Georgia Normal and Industrial School provided required courses in personal hygiene and mothercraft. In 1918, a course in health education for teachers was instituted. The mothercraft course marked one of the first movements in the pioneering field of sex hygiene.

Other than a varied curriculum in health, Georgia State College for Women offered undergraduate degrees in health, one of the first institutions in the United States to do so. Hasslock reported that Georgia State College for Women was "among the first in the country to place great emphasis upon
health education and to maintain a fully organized department for the study of that subject" (12, p. 147).

Rogers, through the offices of education of the United States, conducted research on the status of health education in colleges in 1936. One item that affects women is that the colleges for women seem not so much concerned with matters of health as one hundred years ago, but a larger percentage require more courses than for men. It seems from this point on, women's colleges were being combined with men's colleges when a survey would take place. Therefore, the outstanding achievements made by the women were being overshadowed by the men.
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CHAPTER III

A SURVEY OF THE MAJOR HEALTH NEEDS IN
THE UNITED STATES

The survey undertaken herein was an endeavor to investigate the major health needs in the United States. The review of the professional literature is presented in this chapter in priority sequence, ranging from the most important to that of least importance, as determined by this writer and evidence presented by the National Center for Health Statistics. Only a minimum of reading and observation needs be done to see the evidence of a flourishing abuse of drugs, the morbidity of venereal disease, premature deaths resulting from a variety of chronic diseases, accidents as a leading cause of death and injury to children, youth, young adults and the aged. In addition, along with pollution, low fitness, increased illegitimacy, and a lack of knowledge about health, there is an even greater lack of application of knowledge about health in everyday life (37, p. 81).

René Dubos states,

The modern American . . . claims the highest standard of living in the world, but 10 percent of his income must go for medical care and he cannot build hospitals fast enough to accommodate the sick. He is encouraged to believe that money will create drugs for the cure of heart disease, cancer, and mental disease, but he makes no worthwhile effort to recognize,
let alone correct, the mismanagements of his everyday life that contribute to the high incidence of these conditions. One may wonder indeed whether the pretense of superior health is not itself rapidly becoming a mental abberation (10, p. 31).

The major health areas examined in the chapter are presented in the following order: mental health, alcohol and drugs, venereal disease, heart disease, cancer, accidents, emphysema and bronchitis, sexuality problems, environmental pollution, and consumer health problems.

Mental Health

Leabon E. Martin, in his book Mental Health/Mental Illness, contends that the depth and scope of the problem of mental illness in the early years is pointed out in sobering statistics:

As many as 500,000 children in the United States suffer from psychoses and borderline psychotic conditions.

Another million children are afflicted with personality disorders.

Five million or so of the nation's 50 million school age youngsters have moderate to severe emotional problems.

One out of 3 of the 15 million youngsters reared in poverty has serious mental or emotional problems.

Five hundred thousand or more young people are brought into court each year for antisocial acts.

Suicide is believed to be the fourth-ranking cause of death among fifteen-to-nineteen-year-olds.

The number of children and adolescents in mental hospitals is increasing more rapidly than their increase in the population (26, p. 68).
These facts are overwhelming and seem to indicate that the concept of poor mental and emotional health is of vast importance to the welfare of the individual, the community, and the nation.

John Lemcke adds additional concurrence to the problem of mental and emotional health. He states that the number one health problem in the United States is mental and emotional illness. About one person in ten has a severe enough emotional problem to need special counseling and guidance. The facts also indicate that one-half of all the medical cases treated by private physicians have a mental or emotional complication. Mayer contends that "mental stress, conflict, and anxiety frequently produce ulcers, colitis, hypertension, and even common hives" (28, p. 74). Sinacore refers to the relationship between physical and psychological disorders when he states,

It should also be recognized that real physical disorders and pain can be produced by psychological stress. Any person under tension is reacting not only mentally, but physically as well. In response to these situations there are secretions from the adrenal glands, the pituitary gland, and increased thyroid activity. There is oftentimes involvement of the gastrointestinal tract, as indicated by the relationship of ulcers to long term tensions. The acid production of the stomach is significantly increased during such periods of stress with resultant erosion of its lining. The physical reactions to stress are many and varied and could involve the cardiovascular system, with resultant cardiovascular disease, as well as the respiratory tract with allergies and asthma being common reactions (33, p. 28).
Lemcke also adds that the social and personal problems of divorce, problem pregnancy, delinquency, alcoholism, drug abuse, smoking, overeating, fatigue, and accidents all have a close relationship to the issue of poor mental health (4).

In general, many authors have indicated that the vast number of health and social problems are closely related to the problem of poor mental and emotional health. This concept seems to infer that adequate mental health education for the professional preparation of health educators is necessary to handle many of the other health needs as well.

Alcohol and Drugs

A second health need relates to the problem of drug abuse. Johns, Sutton, and Webster contend that "the present drug scene constitutes one of the gravest health problems facing the nation and has been called the number one health problem of youth today" (18, p. 449). This analysis seems to portray the problem of drug abuse as an epidemic impairing the intelligence, skills, and social functions of an entire population. Thus, it would seem the future of our nation is at stake if education does not come to grips with the drug problem.

Dr. Frederic F. Flach, adds emphasis to this contention by stating,

... that unchecked, this epidemic, and the factors which give rise to it threaten the very
basis of our society. . . . It is reliably estimated that nearly one teenager in three—perhaps in two—has used some form of illegitimate drug having an effect on emotions and behavior . . . primarily acid, speed, pot, barbiturates. More experiment with alcohol" (12, p. 155).

Dr. Leonard D. Jacobson concurs with these remarks. He states,

The age of onset of the use of ethanol is decreasing, as it is with the use of heroin, barbitals, marijuana and other psychoactive drugs. Thirteen year old junkies and alcoholics are not uncommon (17, p. 37).

Dr. Joel Fort contends that alcohol is our biggest drug problem and is also "our most frequently used illegal drug by those under age 21 or 18" (14, p. vi). This analysis seems to contend that a nationwide occurrence of alcohol abuse does exist among the teenage generation in the United States. An article in Newsweek adds further emphasis to this concept by stating that

from nearly every quarter of the nation, school authorities and teenagers themselves report that the latest fad in juvenile drug abuse is one that has a familiar ring to the older generation: the drug of choice these days, they say, is alcohol (25, p. 68).

Venereal Disease

A third health need relates to the problem of venereal disease. Venereal disease is one of the most ravaging of the infectious diseases today. Dr. Donald A. Dukelow states that "syphilis and gonorrhea are endemic among our youth and young adults" (11, p. 223). The point was further
emphasized when Dick Cavette and others made a national television program, *V. D. Blues*, using the talents of the latest rock artists to convey the "word" to the nation's young people. The program was an attempt to tell young people about the dangers of venereal disease.

The American Social Health Association denotes the vastness of the V. D. control problem by reporting that because many cases of gonorrhea are not detected, and many which are treated are not reported, the actual incidence of the disease is not known. The Public Health Service, however, estimates that there were at least 2,500,000 cases of gonorrhea in the United States in FY (fiscal year) 1972. Gonorrhea continues to be reported most frequently from large urban areas. There were 47 United States cities of more than 200,000 population reporting increases up to 118% in FY 1972 (39, p. 10).

Dr. James S. McKenzie-Pollock, director of the Venereal Disease Control Program of the American School Health Association, concurs by stating that "thousands upon thousands of young people simply aren't aware of the dangers of V. D. Once infected they are complacent about treatment" (5, p. 111).

The literature seems to indicate that over the last ten years there has been a great increase in the amount of venereal disease, and that the majority of this increase has been among the teenage population. Jones, Shainberg, and Byer concur with this statement and add that "about one-fourth of all venereal disease cases today are among persons under twenty years of age. The venereal disease rate for
teenagers is higher than it is for any other age group" (19, p. 32).

Mathews makes reference to the extreme anxiety states of patients receiving examinations and treatment for venereal disease. The article portrays the give-and-take between a nurse and clinic patients seen during a typical working morning at the clinic. It shows that patients enter the clinic anxious, worried, or angry (27).

The contention that there is a relationship between poor emotional health and venereal disease is inferred throughout the literature. It would also seem that the vastness of the problem is endemic of the emotional status of the entire United States.

Heart Disease

A fourth health need relates to the problem of heart disease. The National Office of Vital Statistics has listed heart disease as being the number one cause of death in the United States. This fact is reinforced by Smolensky and Haar. They contend that "each year heart disease is responsible for one of every two recorded deaths, killing nearly one million Americans" (35, p. 221). These statistics seem to imply that heart disease causes death among all age groups of Americans and is not just endemic among the middle aged and elderly. Thomas Dawber concurs with this contention when he states that "in recent decades, coronary heart
disease has increased in the United States, and there has also been a growing tendency for this disease to occur in younger age groups, particularly among men" (24, p. 367). Therefore, it seems there is a direct implication that education toward preventive measures in heart disease is necessary for the young American.

The professional literature seems to link heart disease and poor emotional health together. There is an indication that much of the heart disease today can be caused by poor mental-emotional health. One directly related condition is hypertension. Cleveland Hickman states,

Emotion is supposed to play an enormous role in hypertension. This does not refer to emotional outbursts that may temporarily alter the blood pressure, but to a type of personality that follows a certain pattern of repressed emotional turmoil. In such a type, emotional tension is always simmering inside, and only occasionally erupts in a violent outburst. Such a continuous tension produces a constriction of the small arterioles, producing a resistance to blood flow and promoting greater blood pressure" (16, p. 342).

The literature suggests that hypertension causing high blood pressure is a major cause of heart attack and cerebrovascular death.

Roberts suggests that the entire family of a heart patient is also affected by the poor emotional health exemplified by the heart patient. Roberts states,

A problem faced by most heart patients, and one that is of particular importance in working with children, is the chronicity of the condition. Often this results in the whole family's living in a state of chronic anxiety. It is well
documented that anxiety is highly communicable, especially in the parent-child relationship (32, p. 1081).

This would seem to indicate a strong relationship between poor emotional health and heart disease.

Cancer

A fifth health need relates to the problem of cancer. The National Office of Vital Statistics lists cancer as the number two cause of death in the United States. This disease comes in many varied types, strikes in many different locations in and on the human body, and strikes all age groups. Diehl and Dalrymple state,

The chance that a person now under the age of twenty will develop cancer at some time during his or her life is about one in four for males and slightly higher for females. Thus, at present rates more than 50 million Americans now living will eventually get cancer and almost 30 million will die from it (8, p. 68).

The professional literature seems to develop the contention that the problems connected with the degenerative disease cancer are not simply physical in nature. Due to lack of information on the part of a cancer victim, he or she may develop a great fear that he or she is going to die, when in reality he or she may be treated and possibly cured. This emotional stress could possibly contribute to poor mental health conditions not only in the victim but in his or her family and friends.
Klagsbrun contends that the patient with cancer, along with family, friends and medical treatment personnel, undergoes extreme anxiety feelings and emotional health problems. All persons concerned have a need to understand various ways of handling the anxiety of facing something unfamiliar to them (23).

Jean Carper seems to add to this contention by stating that "many women are so fearful of breast cancer they refuse to acknowledge signs of the disease or to get immediate medical attention" (r, p 287). Hence, the possibility that the added anxiety felt by the victim of any cancer, is heightened and may cause poor mental-emotional health problems to occur.

Accidents

A sixth health need relates to the problem of accidents. Florio and Stafford through an analysis of accident data state,

If an epidemic were suddenly to strike this country, killing over 100,000 people, disabling permanently or temporarily, over 10 million others, and injuring over 51 million others, it would be recognized at once as a serious threat to the national economy and social structure (13, p. 1).

Aaron, Bridges, and Ritzel add emphasis to this contention by revealing that "accidents are the major cause of death of persons age one to thirty-seven and the fourth leading cause of death for persons of all ages" (1, p. 3). These facts seem to point toward the graveness of the accident
problem. There seems to be some indication that the rate of some accidents could be caused by persons having some emotional conflict or stress that might cause the person to be "accident prone." John Henderson states that "nearly one-fifth of serious or fatal accidents could probably be prevented if the deep underlying psychologic drives of the perpetrators could have been recognized and corrected before the accident" (15, p. 39). Strasser, Aaron, Bohn and Eales concur with Henderson by stating that

an analysis of accident cases brought into a hospital showed that 90 per cent had instances of provocation, frustration, disappointment, or other emotional factors just before their accidents (36, p. 91).

This would seem to indicate that many of the accidents at home, at work, or at play could be related to the poor emotional health of the individual.

Emphysema and Bronchitis

A seventh health need relates to the problem of emphysema and chronic bronchitis. Miller and Burt contend that "the major single cause of pulmonary disability in the United States is emphysema" (30, p. 424). This disabling disease seems to be linked primarily to smoking. Bayne-Jones concurs with this contention when he states "lung cancer, emphysema, chronic bronchitis, and heart disease are being influenced by smoking" (4, p. 101). These facts portray a grave picture of the tragic effects of smoking on the
human body. The facts also seem to point to a question that is vaguely lurking in the background--is there the possibility that smoking and poor mental health have some relationship?

Dr. Daniel Horn seems to indicate an affirmative to the possibility of the above contention when he states that people smoke for one or more of the following reasons:

1. For stimulation, such as to get started in the morning
2. Because of addiction; this smoker "must have" a cigarette
3. To reduce negative feelings, such as distress, anger, or fear
4. Out of habit--a behavior pattern followed almost involuntarily
5. For oral gratification--the satisfaction derived from something in the mouth
6. For pleasurable relaxation--to enhance positive feelings, such as after a good dinner (9, p. 133).

Some of these reasons, it seems, have given a positive affirmation to the contention that there is a poor emotional health factor involved. Thus, if this contention stands firm, it is reasonable to assume that if a person analyzes his reasons for smoking, he or she might "kick the habit," therefore, decreasing the number of deaths caused by emphysema and chronic bronchitis.

Human Sexuality

An eighth health need relates to the problems associated with human sexuality. Paul Cook has stated that,

Rather than learning about human sexuality in an atmosphere of trust, honesty, and acceptance, we have received a mishmash of confusing and deceptive
information—feelings of shame and embarrassment, and ideas and attitudes concerning sex that are sometimes immoral and often frightening (6, p. 7).

The literature tends to indicate that individuals in our society seemingly are receiving misinformation leading to confusion, shame, and embarrassment concerning human sexual behavior. The evidence seems to suggest that there might be a close relationship between poor human sexual behavior and poor emotional health. Jones, Shainberg and Byer seemingly concur with this contention and add that "a sex problem can be a problem in itself, a symptom of a problem in emotional adjustment, or the result of some difficulty in the complex interaction between a man and a woman" (21, p. 147).

Slansky, Silverman and Rubichow add additional emphasis by suggesting that "during the high school years the emotional and behavioral upheavals are greater than during any other period in a student's life" (34, p. 18). Hence, this tends to increase the problem related to teenage sexuality.

The literature suggests that education toward personal development and the understanding of one's human sexual development is needed. Dr. George Szaz adds emphasis to the contention by proposing that emotional health education and education for human sexuality are essentially related. Szaz contends that it is perhaps evident by now that sex education . . . is essentially an emotional education, more preventive and remedial medicine than moral training. An increasing understanding of human problems . . . might help in creating an atmosphere
in which members of communities may re-examine their value system and come to some reasonable conclusions about accepted limits of various forms of behavior including the sexual one (38, pp. 154-155).

Environmental Health

A ninth health need relates to the problems associated with environmental pollution. Robert Baskervill states,

The problem of air pollution has increased in the United States since the early nineteen forties... the problem may reach critical proportions affecting the health of every man, woman, and child—unless measures are taken to impose controls on the amount of toxic pollutants which are dispersed into the atmosphere (2, p. 377).

Brennan adds that "air pollution, like cigarette smoking in the not too distant past, has been linked with illness" (3, p. 377). Throughout the literature, evidence tends to show a strong relationship between air pollution and diseases such as emphysema, chronic bronchitis, heart disease, and poor emotional health. Baskervill makes reference to the contention on poor emotional health when he states that

a problem usually occurs when pollution is sufficient to cause annoyance, insult to the sense perceptions, or deleterious effects on the environment, such as: haze, odor, smoke, dust soiling, corrosion, eye irritation, respiratory symptoms, or other physiological and psychological responses (2, p. 377).

Jones, Shainberg and Byer address another type of pollution problem and contend that noise pollution (as well as air pollution) in the environment not only causes physiological health problems, but also has a direct reaction on
the mental and emotional health of people. They contend that probably the most damaging effect of noise pollution on the quality of human life is its disruption of our psychic balance. Loud, harsh, or persistent noise robs us of our peace of mind, puts our nerves "on edge" so that our relationships with each other are strained and often explosive, interferes with our concentration, and impairs the efficient functioning of our minds. Noise must be regarded as far more than just an annoyance; it is an important factor contributing to the reduction of the quality of our lives (20, p. 23).

Diehl and Dalrymple concur with this statement and add emphasis by stating that contributing to nervous disorders, insomnia, nervous tension, ill temper, and accidents, noise pollution has become a serious problem in most communities (8, p. 31).

These facts indicate that both noise and air pollution are contributors to poor emotional health.

Consumer Health

A tenth health need relates to the problems associated with consumer health. Change in America is a certainty, and with this change the consumer must adapt to the marketplace where change is commonplace. Cornacchia draws attention to the problems that the consumer encounters when he states, Attention and concern for the consumer is gaining increased emphasis by individuals in the private and public sector today. The emergence of this problem is related to the unrest resulting from numerous unethical practices and misleading procedures utilized in the business world. There is a widely expressed growing need for fairness, justice, and honesty in the economic arena (7, p. 2).
The American consumer, therefore, could encounter various degrees of problems. He might have difficulty in making ends meet, or in avoiding the pitfalls of irresponsible credit use. It is, therefore, reasonable that when and if these problems occur, the emotional and mental health of the individual and his family could be impaired. Read and Greene add to this contention when they state that the occurrence of some degree of illness in the lives of most persons is a virtual certainty; its threat dictates that we prepare for it; and its actuality often forces us to enter the market in search of health products and services. Here one encounters much the same type of problems that are characteristic of other realms of the American marketplace; however, the stakes are somewhat higher, as both one's health and pocketbook are dependent upon the intelligence of one's purchases (31, p. 387).

Dr. John S. Sinacore seems to have diagnosed a plausible reason for the problems of the American consumer. He adds that:

many of our schools add to the problem by omitting from their curricula health instruction that is concerned with the many vital health issues of our society. The school, the agency that should serve as a major source of health information, often fails to do so. The health consumer is thus ripe for plucking (33, p. 262).

Kime and Jarvis concur with Sinacore and add that:

helping students discover how commercial advertisers exploit their fears by amplifying them helps the students to realize that most of their anxieties are relatively groundless and also that they are shared by many (22, p. 9).

McMahon and Tifft add emphasis for change by stating that:

the American public has harbored misconceived ideas about consumer matters related to their
own health and will continue to do so unless effective consumer health education occurs. Health, happiness, and our very lives depend on it (29, p. 14).

The survey of major health needs investigated herein indicate curriculum areas that could be used in the professional preparation of public school health educators. There is one important factor present in all of the curriculum areas—a relationship to poor mental and emotional health. The prospect of this contention needs further analysis.
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CHAPTER IV

A SURVEY TO DETERMINE THE DEGREE OF ATTENTION GIVEN TO CURRICULUM AREAS IN CURRENT BACHELOR DEGREE PROGRAMS OF HEALTH EDUCATION IN THE UNITED STATES

In this section of the study, an attempt was made to determine the degree of attention given to curriculum areas in current health education bachelor degree programs in the United States. The data were gathered by means of a questionnaire survey that was mailed to colleges and universities in the United States offering undergraduate professional preparation programs in health education. The list of colleges and universities surveyed was taken from the 1974 Eta Sigma Gamma, professional health education honorary society listing, and the United States Department of Health Education and Welfare's Health Resources Statistics, Health Manpower and Health Facilities, 1971 report. The persons receiving the questionnaire were directors or chairmen of the undergraduate programs. The survey began in September, 1974, and was completed in November, 1974.

The questionnaire used in the survey was examined by a jury of experts in the field of health education prior to its being formally distributed across the United States. All of the judges agreed that the items in the questionnaire
were valid points needing investigation and clarification for the profession. The judges were as follows:

Charles Atwell, Ed. D.
Virginia Polytechnic Institute and State University
Blacksburg, Virginia 24061

B. J. Brown, Ed. D.
Virginia Polytechnic Institute and State University
Blacksburg, Virginia 24061

Robert H. McCollum, Ed. D.
Virginia Polytechnic Institute and State University
Blacksburg, Virginia 24061

Jerry Ainsworth, Ed. D.
Southern Connecticut State College
New Haven, Connecticut 06500

Bryan Gray, Ed. D.
North Texas State University
Denton, Texas 76203

Parris Watts, H. S. D.
North Texas State University
Denton, Texas 76203

Gloria Williamson, Ph.D
North Texas State University
Denton, Texas 76203

The judges unanimously decided on a total of eight specific questions relevant to the study being undertaken. (See Appendix A.)

A total of seventy-six colleges and universities within the continental United States were sent the questionnaire, and a total of seventy questionnaires were returned by the participating institutions. This represented a 92.1 percent return for the survey conducted.
Degree Program Placement

Figure 1 illustrates the current department or discipline housing the undergraduate program in health education.

Fifty per cent of the institutions completing the survey indicated that their undergraduate program was housed in a separate health education or health science department. Of the institutions answering the survey, 25.71 per cent indicated that their program was housed in a health and physical education department. Ten per cent indicated that their program was housed in a health, physical education, and recreation department. Five point seventy-one per cent indicated that their program was housed in a specific physical education department.
education department, and another 5.71 per cent indicated that their undergraduate program was housed within the education department. One point forty-two per cent states that their program was housed in a college of life sciences, while another 1.42 per cent indicated that their program was housed in a department of counseling, health, and rehabilitation.

Type of Degree Awarded

Figure 2 indicates the type of undergraduate degree awarded by the institutions surveyed. The data indicate that 75.71 per cent of the institutions returning the survey award a specific health education or health science degree.

A total of 11.42 per cent award their student graduates with a general health, physical education, and recreation degree.
Twelve point eighty-five per cent of the institutions offer a general Bachelor of Science or Bachelor of Arts degree either in the department of education or other professional field areas.

**Required Health Education Course Hours**

Item number three of the questionnaire indicated the total number of health education course hours required for teacher certification by a health educator for those participating in the survey. Sixty-one point forty-two per cent of the schools answering the survey are on the semester system, while 38.5 per cent of the schools surveyed are on the quarter system. The data indicate that the average number of health education course hours required by those institutions on the semester system are 31.90 hours. Those schools on the quarter system indicate that the average number of health education course hours required are 48.52 hours.

**Estimated Number of Health Education Students in United States**

Figure 3 on page 60 illustrates the estimated number of undergraduate students enrolled in the professional teacher preparation programs of those institutions of higher education participating in the survey. A total of six categories or ranges of estimated student enrollment was established in the questionnaire for the convenience of the respondent. A total of sixteen schools checked category I; nineteen
<table>
<thead>
<tr>
<th>Estimated Number of Students</th>
<th>Schools Answering Survey</th>
<th>Median Number of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. 1-25</td>
<td>16</td>
<td>200.00</td>
</tr>
<tr>
<td>II. 25-50</td>
<td>19</td>
<td>712.50</td>
</tr>
<tr>
<td>III. 50-75</td>
<td>7</td>
<td>437.50</td>
</tr>
<tr>
<td>IV. 75-100</td>
<td>12</td>
<td>1050.00</td>
</tr>
<tr>
<td>V. 100-150</td>
<td>3</td>
<td>375.00</td>
</tr>
<tr>
<td>VI. 150 and above</td>
<td>11</td>
<td>1925.00</td>
</tr>
</tbody>
</table>

Fig. 3--Estimated number of students in the professional health education curriculum survey.

checked category II; seven, category III; twelve, category IV; three, category V; and eleven checked category VI. Two schools were not responsive to this item in the questionnaire. The median estimated number of students enrolled in professional health education curriculums in the United States was 4800.00. The estimate indicated herein may have significance in the future, as health problems possibly increase and health agencies within our communities have need for health education personnel. One question that arises from the above analysis is--Will we have enough adequately trained personnel to meet the nation's needs?

Professional Preparation of Faculty in Undergraduate Health Education Programs

This section is concerned with presenting the data related to question number four on the survey. Figure 4, page 61, delineates the professional preparation training of the personnel across the United States in institutions of higher education who teach potential public school health
Degree Held by Faculty

A. Health Education  
B. Health, Physical Education, and Recreation  
C. Physical Education  
D. Remainder of Faculty (Adjunct and Professional Health People)

Fig. 4--Types of degrees held by faculty educators. The percentage of health education degree persons was 62.91 per cent, while the percentage of health, physical education, and recreation degree persons was 12.73 per cent. Specific physical education degree persons totaled 6.55 per cent, while the remainder of the faculty made up 17.82 per cent.

Courses of Study in Health Education  
Undergraduate Programs

Figure 5 on page 62 indicates the individual courses of study taught in the professional preparation programs of public school health educators by those institutions participating in the survey. The courses are listed in the same order as they are in the survey. (See Appendix A.)
<table>
<thead>
<tr>
<th>Courses</th>
<th>Number of Schools Answering Survey</th>
<th>% of Schools Teaching Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Education</td>
<td></td>
<td>84.28</td>
</tr>
<tr>
<td>Mental/Emotional Health</td>
<td></td>
<td>78.57</td>
</tr>
<tr>
<td>Human Sexuality</td>
<td></td>
<td>91.42</td>
</tr>
<tr>
<td>Communicable Diseases</td>
<td></td>
<td>68.37</td>
</tr>
<tr>
<td>Chronic, Degenerative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Health: Methods/Materials</td>
<td></td>
<td>94.28</td>
</tr>
<tr>
<td>Public/Community Health</td>
<td></td>
<td>85.71</td>
</tr>
<tr>
<td>Personal Health</td>
<td></td>
<td>92.85</td>
</tr>
<tr>
<td>Environmental Health</td>
<td></td>
<td>60.00</td>
</tr>
<tr>
<td>Safety Education</td>
<td></td>
<td>65.71</td>
</tr>
<tr>
<td>First Aid</td>
<td></td>
<td>82.85</td>
</tr>
<tr>
<td>Consumer Health</td>
<td></td>
<td>40.00</td>
</tr>
<tr>
<td>Organization/Administration</td>
<td></td>
<td>81.42</td>
</tr>
<tr>
<td>School Health Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Historical/Philosophical Foundations of Health</td>
<td></td>
<td>40.00</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>32.85</td>
</tr>
</tbody>
</table>

Fig. 5--Number and percentages of schools teaching individual courses in their curricula.
The total number of schools participating in the survey is listed in Figure 5 and the number of schools answering the survey that teach the individual courses is also listed. All seventy of the schools answering the survey indicated that they taught many of the same courses. However, only 40 per cent of the schools indicated that they taught courses in consumer health or historical and philosophical foundations of health. Sixty per cent indicated that they taught a course in safety education and only 68.57 per cent indicated that they taught a course in communicable, chronic, and degenerative diseases. Thirty-two point eighty-five per cent of the schools indicated that they taught courses in nutrition, epidemiology, counseling, child development, and evaluation. This is represented on the graph in Figure 5 by the item entitled "other."

A large number of respondents answered "no" to item seven on the survey which attempted to determine if there was a nucleus or core area around which the teacher preparation program evolved. Ninety-eight point fifty-seven per cent answered "no" to the question. Only one university answered this question in the affirmative. The University of Maine at Orano indicated that they had a core area. The core area indicated was family life education.

The information obtained from the institutions of higher education answering the survey was analyzed and ideas
were obtained for constructing the professional preparation curriculum model described in Chapter V.
CHAPTER V

THE DEVELOPMENT OF A COMPREHENSIVE PROFESSIONAL PREPARATION PROGRAM FOR PUBLIC SCHOOL HEALTH EDUCATORS

In order to develop a comprehensive professional preparation program for public school health educators, three major inputs were incorporated. The first input was a survey of the historical development of health education in higher education in the United States from 1800 to the present. The second input involved a survey of the major health needs or curriculum areas in the United States. The third input was a questionnaire survey to determine the degree of attention given to curriculum areas in current health education bachelor degree programs in the United States. Based upon the information derived from these three inputs, a conceptual curriculum model advocating a comprehensive professional preparation program in higher education for public school health educators was developed.

The survey of the historical development of health education in higher education in the United States from 1800 to the present revealed that little emphasis has been placed on the professional preparation of public school teachers in health education. The infant beginning of the professional preparation program for public school health
education teachers was delimited to mere flatulant verbage espoused by several educators during the early 1940's and 1950's. This was the case until the later part of the 1960's. However, at this point in time, the professional preparation program had matured to an adolescent stage of development, and this is presently the status of the teacher preparation programs in health education within the United States. One sustained reason for the lack of growth was the relative conservatism of education in general, and because administrators were also somewhat conservative in nature. Health education was not considered worthy of study; it supposedly lacked aesthetic value.

However, by the mid 1960's, the School Health Education Study, which was developed for the purpose of improving health instruction programs in schools, was completed and the results and recommendations were reported to the nation. The findings and recommendations made in this study mark health education's maturity from an infant stage to that of an adolescent stage. The survey of the historical development of health education in higher education in the United States is only a portion of the foundation upon which the development of a comprehensive professional preparation program for public school health educators is constructed.

The second component of the study, a survey of the major health needs in the United States, was undertaken, and the results indicated that the areas examined all had a
close relationship to the problem of poor mental and emotional health. The areas examined were mental health, alcohol and drugs, venereal disease, heart disease, cancer, accidents, emphysema and bronchitis, sexuality problems, environmental pollution, and consumer health problems.

Many authors have contended that the vast number of health and social problems, specifically those areas examined by this study, are problems complicated either by poor emotional or mental health, or they are ends derived from poor emotional or mental health.

The inferences drawn from this survey give impetus to the development of a comprehensive professional preparation program for public school health educators as an alternative to separate courses to allow more cohesiveness within the curriculum. The survey of major health needs investigated indicated curriculum areas that could be used in professional preparation programs. Again, there is one important factor present in all of the curriculum areas—a relationship to poor mental and emotional health. The prospect of this contention being a basis or foundation for a professional preparation program for public school health educators is important. One distinct reason indicating importance is that the curriculum will be more unified. Another reason is that the above contention is a basis from which all other course curriculum matter interrelates.
The third component, the questionnaire survey to determine the degree of attention given to curriculum areas in current health education bachelor degree programs, revealed several points of significance. First, the overall return of the questionnaire by the participating institutions was excellent, and a 92.1 per cent return was tabulated. The overwhelming response to the questionnaire showed a significant interest in the status quo of health education. Second, an inference drawn from the survey indicated that health instruction within the professional preparation programs has emphasized individual courses such as physical fitness, anatomy, safety, human sexuality and others, rather than showing a relationship to all of the health curriculum areas as postulated in the survey of health needs.

Based on the findings and inferences derived from the three major inputs described in this study, the development of a comprehensive professional preparation program for public school health educators was constructed. The results and recommendations of that construct are described herein.

The curriculum model advocated is circular in nature and resembles the formation of a wheel. The hub or core of the model would contain a course or courses of study in mental health. This area would strongly emphasize personal development and the understanding of how to identify signs and symptoms of extreme tension, anxiety and frustration in oneself and others. The course or courses of the "core"
would also indicate ways to diagnose and handle the signs and symptoms of poor mental and emotional health in oneself and others on a non-medical basis.

Mental and emotional health was selected as the core area of the model for the following reasons: (1) the survey of health needs discussed in Chapter III of this study revealed that there was one important factor present in all of the areas investigated—a relationship to poor mental and emotional health; and (2) that the theme of mental and emotional health was inferred throughout the ten concepts in the School Health Education Study program. Therefore, the present model is unique in that it emphasizes the two-way relationship between the mental health core and the other health areas. Not only is mental health the core or foundation of this model, it is also the major emphasis of any classroom program dealing with the other health issues.

Figure 6 on page 70 presents the curriculum model in more graphic detail. The "spokes" within the model represent the various curriculum areas or health needs as reported in Chapter III of this study. Each spoke would represent a course of study in the professional teacher preparation curriculum. Within each of the courses of study, factual information, health concepts, and values clarification for the student would be presented, along with specific health education methodology for teaching various age and grade levels.
*Indicates semester hour credit for each course.

Fig. 6--Comprehensive professional preparation curriculum model.

In addition, several teaching-learning experiences need to be incorporated within the courses of study and the proposed curriculum. First, the cognitive, affective, and action domain areas of health must be utilized and taught in the various courses. Second, a relationship between poor mental and emotional health and the stated health problems must be presented to the prospective teacher within the teaching experience offered during each course of study.
Third, the characteristics of children of different ages must be identified for and by the prospective teacher. Fourth, the application of learning theory as it applies to children of different age and grade levels should also be embodied in each of the courses within the curriculum.

The first of the four elements listed above includes objectives which deal with factual knowledge and the development of intellectual skills. This area is known as the cognitive domain. The affective domain area emphasizes objectives dealing with values clarification, attitudes, and emotions or feelings. The action domain area emphasizes the use of physical behavior as an expression of the other two domain areas. The skilled teacher will utilize all of these three domain areas, and may interrelate all three in teaching. The major teaching strategy that can be utilized with the cognitive, affective, and action domain areas is that of the "behavioral or performance objectives" approach.

The second element listed should emphasize that a relationship between poor mental and emotional health and the stated health problems does exist. This relationship must be introduced by the teacher to the students through objectives dealing with the three domain areas. This must be done in each course of study within the professional preparation curriculum.

The third element listed should emphasize that the characteristics of children of different ages must be
identified for and by the prospective teacher. This element is vastly important. The physical, mental, emotional, and social characteristics of girls and boys, if known and observed by the prospective teacher, will enable him or her to understand the growth and development taking place within their students.

The fourth element listed should emphasize the application of learning theory as it applies to children of different age and grade levels. The prospective teacher must understand and apply some type of learning theory within the teaching process. Again, the characteristics of children of different ages and grade levels will determine how well the health material is learned and utilized by the students.

The aforementioned elements give a more definitive strength to the courses of study within the curriculum model. The model, however, is only an extension of the conceptual curriculum design developed in the School Health Education Study completed in 1965. The professional preparation model developed in this section of the study attempts to strengthen the conceptual approach as applied to teaching health.

An additional course of study assessing the principles of organization and administration of health education in the public schools fits into the model. The course will strongly emphasize the continued evaluation and development of other health needs or curriculum areas as the problem
presents itself. The course of study will emphasize personnel management procedures and the development of personal skills in dealing with faculty and allied professionals.

In addition to the criteria developed for the curriculum model in this study, a set of course guidelines has been prepared to assist those institutions involved in the professional preparation of school health educators. (See Appendix B.) The course guidelines were developed as an attempt to give clarity to the comprehensive health education curriculum. They in no way are an attempt to take away from the creativity and resourcefulness of the individual health educator, but rather a guide conceptualizing the direct relationship between the health need areas surveyed in Chapter III and the concept of mental and emotional health.

The comprehensive program proposed in this study develops the concept that the thrust of health education should be directed toward the development of a positive mental and emotional health concept within the individual. Within the program each course relates to the concept of positive mental and emotional health.

In the analysis of data taken from the survey described in Chapter IV, it was found that the average number of professional health education course hours was 31.9 semester hours. The average number of course hours of those schools on the quarter system, when converted to semester hours, was about the same as that above, 32.4 semester hours. Based
on the findings of this data, the proposed professional curriculum described herein should also contain thirty to thirty-two required semester hours. The curriculum model and the course hours proposed could be implemented in all of the current health education bachelor degree programs in the United States. This would add uniformity to the training of health educators in our professional preparation programs.

The comprehensive professional preparation program for public school health educators described herein will provide the potential health teacher with a basic understanding of a correlation between the health need areas and poor mental and emotional health. This is a possible answer to our health problem dilemma.

The purpose of this chapter was to develop a comprehensive professional preparation program for public school health educators. The major objective of this part of the study was to give potential health educators a central point of embarkation from which to move into a study of the major health needs in the United States and a point of reference toward which they can return with clarity and ease. The understanding of the relationship of all of the health needs covered in the curriculum with poor mental and emotional health is essential for the teacher of health education in the public schools. The literature has substantiated this concept repeatedly.
Recommendations

The following are recommendations based on the results of this study:

1. It is recommended that the department housing the undergraduate degree program in health education be in a separate health education division or health science department.

2. It is recommended that a specific health science or health education degree be awarded to graduates rather than several other types of degrees.

3. It is recommended that faculty who teach in the professional preparation programs hold health science or health education degrees or that they be retrained in the health areas within five years from the date set down by the state certification boards of each state.

4. It is recommended that the proposed curriculum model be implemented in one or two institutions offering professional preparation public school health education programs on the bachelor level.

5. It is recommended that during the implementation, or trial period, that the courses of study be continually updated and evaluated to determine their correctness and effectiveness in material presented.

6. It is recommended that further study be done to determine if a competency-based program could be implemented using the developed curriculum model.
APPENDIX A

September 16, 1974

Dear Health Educator:

Enclosed is a brief questionnaire survey that I am conducting throughout the United States. The questionnaire was developed to determine the degree of attention given to curriculum areas in current bachelor degree programs of health education.

We who are in the field of health education realize the need for proper professional preparation of the young people who are fitted for, and interested in becoming, health education teachers. Since your background and interest is in health education, your cooperation in this phase of the study is needed; and I am, therefore, asking your assistance.

Please complete the enclosed questionnaire at your earliest opportunity and return it in the business reply envelope provided for your use. Thank you for your quick reply.

Sincerely yours,

Joseph T. Miller
Health Education
October 16, 1974

Dear Health Educator:

In September, 1974, you received a questionnaire for a survey that I am conducting throughout the United States. The questionnaire was developed to determine the degree of attention given to curriculum areas in current bachelor degree programs of health education.

If you have not completed and returned the questionnaire, would you please complete the enclosed form as soon as possible and return it in the enclosed envelope. Thank you for your assistance in this matter.

Sincerely yours,

Joseph T. Miller
Health Education
A SURVEY TO DETERMINE THE DEGREE OF ATTENTION GIVEN TO CURRICULUM AREAS IN CURRENT BACHELOR DEGREE PROGRAMS OF HEALTH EDUCATION IN THE UNITED STATES

1. Please indicate by placing a check in the appropriate space, the department or discipline housing the undergraduate degree program in health education.

   - Health education
   - Physical education
   - Health and physical education
   - Education
   - School of nursing
   - Other: Specify _______________________

2. The undergraduate health degree awarded is:

   - A general HPER or HPE degree
   - A specific health education or health science degree
   - A biology or zoology degree
   - A general science degree
   - A nursing degree
   - A home economics degree
   - Other: Specify _______________________

3. Please indicate in the appropriate space the total number of health education course hours required for teacher certification of a health educator by your institution.

   - Semester hours
   - Quarter hours
SURVEY

4. Please indicate by placing a check in the space provided the number of students your institution has in the professional health education curriculum.

   ____ 1 to 25
   ____ 25 to 50
   ____ 50 to 75
   ____ 75 to 100
   ____ 100 to 150
   ____ 150 and above

5. Please indicate in the space provided the number of faculty who teach in your institution's health education curriculum.

<table>
<thead>
<tr>
<th>Full Professor</th>
<th>Associate Professor</th>
<th>Assistant Professor</th>
<th>Instructor</th>
<th>Graduate Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health education degree person</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPER-degree person</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical educator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biologist or zoologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home economics specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary or elementary education specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: Specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Indicate by placing a check next to the item the individual courses of study taught in your institution's curriculum in the professional preparation of health educators.

___ Drug education (includes alcohol and tobacco)
___ Mental and emotional health
___ Human sexuality
___ Communicable, chronic, and degenerative diseases
___ School health education: methods and materials
___ Public and community health
___ Personal health (a survey course)
___ Environmental health
___ Safety education
___ First aid
___ Consumer health education
___ Organization and administration of school health programs
___ Historical and philosophical foundations of health
___ Other: Specify __________________________________________________________

7. Does your institution have a "core area" of health that is basic for your professional teacher preparation program? (An example of the "core area," might be, "Family Life Education." This indicates that the teacher preparation program is built around this nucleus area.)

___ Yes
___ No
SURVEY

3. In question 7 on the preceding page, if the answer was Yes, please indicate the one "core area" identified as that area which your teacher preparation program is built around in the space provided below.

________________________________________________________________________

________________________________________________________________________

Remarks:
________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

INSTITUTION:___________________________________________________________

ADDRESS:____________________________________________________________
APPENDIX B

COURSE GUIDELINES

Mental and Emotional Health Care

A. A study of the historical overview of man's attempt to achieve positive mental health in the United States and throughout the world.

B. A study of mental health as an integral part of total health.
   1. A study of the relationship between mental-emotional health and physical health.
   2. A study of the mental mechanisms used by man, such as, rationalization and projection.

C. A study of the environmental effects on a person's mental-emotional health such as his family, community and school.

D. A study of the basic physical and psychological needs of an individual and how he attains those needs.

E. A study of the identification of stress factors and symptoms of mental and emotional problems.

F. A study of personal development and comprehension of the signs and symptoms of extreme tension, anxiety and frustration in oneself and others.

G. A study of the various means of obtaining services for mental and emotional problems.

H. A study of various suggestions for therapeutic treatment and referral of the victims of mental and emotional health problems.

I. A study of the various means of handling tension and anxiety.

J. A study of the introduction of various teaching methods and techniques for mental and emotional health education.
   1. A study of conceptual teaching as it relates to mental and emotional health education.
2. A study of writing behavioral or performance objectives that deal with mental and emotional health.

3. A study of the values clarification approach and its relationship to the emotional and mental well-being of the individual.

4. A performance or teaching experience will be incorporated within the course of study.

K. A study of the identification and the characteristics of children of different ages and grade levels as it pertains to mental and emotional health education.

L. A study of the introduction and relationship of various types of learning theory as it applies to children of different age and grade levels and as it pertains to mental and emotional health education.

M. A study of mental health and the public schools.

1. A study of the relationship of education and mental and emotional health.

2. A study of the contribution of education to learning capabilities and personality strength in youth.

3. A study of psychological objectives and teaching.

4. A study of understanding adolescent needs.

5. A study of the emotions and their link to education.

6. A study of student mental health and the prevalence of suicide.


8. A study of the role of the classroom teacher in spotting troubled students and rendering assistance.

**Alcohol and Drugs**

A. Introduction and status of the problem.

B. Basic facts and cognitions of alcohol and drugs.

1. Drug abuse and its effects on emotions and behavior.
2. Physiological effects of drug abuse to emotional behavior.

C. The relationship of drug abuse to emotional and mental health.

1. A study of personal development and comprehension of the signs and symptoms of extreme tension, anxiety and frustration in oneself and others as related to abuse of alcohol and drugs.
   a. A study of various means of obtaining services for alcohol and drug related problems.
   b. A study of various suggestions for therapeutic treatment and referral of alcohol and drug victims.

2. A study of the identification of stress factors often leading to drug use or abuse and symptoms of mental and physical dependence upon alcohol and drugs.

3. A study of various means of handling tension and anxiety by alternatives to drug abuse as a course of action.

D. The introduction of various teaching methods and techniques for alcohol and drug education.

1. A study of conceptual teaching as it relates to alcohol and drug education.

2. A study of writing behavioral and performance objectives that deal with alcohol and drug education. (These objectives will have emphasis and show relationship to good mental and emotional health).

3. A study of the values clarification approach and its relationship to the emotional and mental well-being of the individual who uses or might use drugs (either in a positive or negative manner).

4. A study of the relationship of values clarification to the conceptual approach in dealing with alcohol and drugs.

5. A performance or teaching experience will be incorporated within the course of study.

E. A study of the identification and the characteristics of children of different ages and grade levels.
F. A study of the introduction and relationship of various types of learning theory as it applies to children of different age and grade levels and as it pertains to alcohol and drugs.

Heart Disease

A. Introduction and status quo of the problem.

B. Basic facts and cognitions about heart disease.

1. Heart disease and its effects on emotions and behavior. (This concept also should be investigated from this point of view—emotions and behavior and its contribution to cardiovascular disease).


C. The relationship of poor emotional and mental health to heart disease.

D. The introduction of various teaching methods and techniques for heart disease education.

1. Conceptual teaching as it relates to heart disease.

2. Writing behavioral and performance objectives that deal with heart disease. (These objectives will have emphasis and show relationship to good mental and emotional health).

3. Values clarification approach and its relationship to the emotional well-being of the individual who has heart disease or is a potential heart disease victim.

4. The relationship of values clarification to the conceptual approach in dealing with heart disease education.

5. A performance or teaching experience will be incorporated within the course of study.

E. Heart disease education and the identification and characteristics of children of different ages and grade levels receiving heart disease education.
F. The introduction and relationship of various types of learning theory as it applies to children of different age and grade levels and as it pertains to heart disease education.

G. Evaluation techniques dealing with heart disease education.
   1. The function and criteria of measurement.
   2. The measurement of health knowledge and attitudes as they pertain to heart disease education.

Cancer
A. Introduction and status quo of the problem.
B. Basic facts and cognitions concerning cancer.
   1. Cancer and its effects on emotions and behavior of the patient, his family, friends and medical attendants.
   2. Physiological effects of cancer and the relationship to emotional health.
C. The relationship of cancer to poor emotional and mental health.
D. The introduction of various teaching methods and techniques for cancer education.
   1. A study of the conceptual teaching as it relates to cancer education.
   2. A study in writing behavioral and performance objectives that deal with cancer education. (These objectives will have emphasis and show relationships to good mental and emotional health).
   3. A study of the values clarification approach and its relationship to the emotional well-being of the individual who has cancer or is a potential cancer victim.
   4. A study of the relationship of values clarification to the conceptual approach in dealing with cancer education.
5. A performance or teaching experience will be incorporated within the course of study.

E. A study of cancer education and the identification and characteristics of children of different ages and grade levels receiving cancer education.

F. A study of the introduction and relationship of various types of learning theory as it applies to children of different age and grade levels and as it pertains to cancer education.

G. A study of the evaluation techniques dealing with cancer education.
   1. A study of the function and criteria of measurement.
   2. A study of the measurement of health knowledge and attitudes as they pertain to cancer education.

Venereal Disease

A. Introduction and status of the VD problem.

B. Basic facts and cognitions of venereal disease.
   1. Venereal disease and its effects on emotions and behavior.
   2. Physiological effects of VD and the relationship to emotional behavior.

C. The relationship of venereal disease to poor emotional and mental health.

D. The introduction of various teaching methods and techniques for venereal disease education.
   1. Conceptual teaching as it relates to VD education.
   2. Writing behavioral and performance objectives that deal with VD education.
   3. Values clarification approach and its relationship to the emotional and mental well-being of the individual who is infected or apprehensive about infection of VD.
   4. The relationship of values clarification to the conceptual approach in dealing with VD education.
5. A performance or teaching experience will be incorporated within the course of study.

E. Venereal disease education and the identification and characteristics of children of different ages and grade levels receiving VD education.

F. The introduction and relationship of various types of learning theory as it applies to children of different age and grade levels and as it pertains to VD education.

G. Evaluation techniques dealing with venereal disease education.
   1. The function and criteria of measurement.
   2. The measurement of health knowledge and attitudes as they pertain to VD education.

Accidents

A. Introduction and status quo of the problem.

B. Basic facts and cognitions concerning various types of accidents.
   1. The analysis of the accident data revealing the epidemic proportions of such, and the major impacts imposed on the individual before and after the accident occurs.
   2. Accidents and their effects on the emotions and behavior of the victim, his family, friends and economic condition.

C. The relationship of accidents to poor emotional and mental health.
   1. A study of accident proneness.
   2. A study of fatigue.
   3. A study of emotional trauma.

D. A study of the introduction of various teaching methods and techniques for accident education.
   1. A study of the conceptual teaching as it relates to accident and safety education.
2. A study in writing behavioral and performance objectives that deal with accident and safety education. (These objectives will have emphasis and show relationships to good mental and emotional health).

3. A study of the values clarification approach and its relationship to the emotional well-being of the individual who is involved in an accident or is a potential accident victim.

4. A study of the relationship of values clarification to the conceptual approach in dealing with accident and safety education.

5. A performance or teaching experience will be incorporated within the course of study.

E. A study of accident and safety education and the identification and characteristics of children of different ages and grade levels receiving accident instruction.

F. A study of the introduction and relationship of various types of learning theory as it applies to children of different age and grade levels and as it pertains to accident and safety education.

G. A study of the evaluation techniques dealing with accident and safety education.

1. The function and criteria of measurement.

2. The measurement of health knowledge and attitudes as they pertain to accident and safety education.

Emphysema and Bronchitis

A. Introduction and status quo of the problem.

B. Basic facts and cognitions of emphysema and bronchitis.

1. Smoking as a primary cause of emphysema and chronic bronchitis.

2. Emotional health and its contribution to emphysema and chronic bronchitis.

3. Emphysema and chronic bronchitis and their effects on emotional behavior.
C. The relationship of poor emotional and mental health to emphysema and chronic bronchitis.

1. A study of personal development and the understanding of how to identify signs and symptoms of extreme tension, anxiety, and frustration in oneself and others.

2. A study of how to identify stress factors often leading to attacks of chronic bronchitis and emphysema.

D. The introduction of various teaching methods and techniques for emphysema and bronchitis education.

1. A study of the conceptual teaching as it relates to emphysema and bronchitis education.

2. A study in writing behavioral and performance objectives that deal with emphysema and bronchitis education.

3. A study of the values clarification approach and its relationship to the emotional and mental well-being of the individual who has emphysema or chronic bronchitis or who potentially might contract the disease.

4. A study of the relationship of values clarification to the conceptual approach in dealing with emphysema or chronic bronchitis.

5. A performance or teaching experience will be incorporated within the course of study.

E. A study of the identification and the characteristics of children of different ages and grade levels who might become or already are smokers.

F. A study of the introduction and relationship of various types of learning theory as it applies to children of different age and grade levels and as it pertains to emphysema and bronchitis education.

G. A study of evaluation techniques dealing with emphysema and bronchitis education.

1. A study of the function and criteria of measurement.

2. A study of the measurement of health knowledge and attitudes as they apply to emphysema and bronchitis education.
Sexuality Problems

A. Introduction and status of various problems concerning human sexuality.

B. Basic facts and cognitions concerning human sexuality.
   1. Human sexual behavior and its effects on emotions and behavior of the individual.
   2. Physiological effects and human sexual response and the relationship to mental and emotional health.

C. The relationship of human sexuality to emotional and mental health.
   1. A study of personal development and comprehension of the signs and symptoms of extreme tension, anxiety and frustration in oneself and others as related to human sexuality and human sexual response.
      a. A study of the various services available to individuals with sexuality problems.
      b. A study of various suggestions for therapeutic treatment and referral for individuals or couples having sexuality problems.
   2. A study of the identification of stress factors often leading to sexual problems and the identification of symptoms of human sexual trauma in individuals.
   3. A study of various means of handling tension, and anxiety by alternative to human sexual behavior as a course of action.

D. The introduction of various teaching methods and techniques for human sexuality education.
   1. A study of conceptual teaching as it relates to human sexuality education.
   2. A study of writing behavioral and performance objectives that deal with human sexuality education. (These objectives will have emphasis and show relationship to good mental and emotional health).

E. A study of the identification and the characteristic of children of different ages and grade levels as it relates to human sexuality education.
F. A study of the introduction and relationship of various types of learning theory as it applies to children of different age and grade levels and as it pertains to human sexuality education.

G. A study of evaluation techniques dealing with human sexuality education.
   1. A study of the function and criteria of measurement.
   2. A study of the measurement of health knowledge and attitudes as they pertain to human sexuality education.

Environmental Pollution

A. Introduction and status of various problems concerning environmental pollution.

B. Basic facts and cognitions concerning environmental pollution problems.
   1. Environmental pollution and its effects on emotions and behavior of individuals.
   2. The analysis of environmental pollution data revealing the major impacts imposed on the individual.

C. The relationship of environmental pollution to poor emotional and mental health.

D. The introduction of various teaching methods and techniques for environmental pollution education.
   1. A study of conceptual teaching as it relates to environmental pollution education.
   2. A study in writing behavioral objectives and performance objectives that deal with environmental pollution problems.
   3. A study of the values clarification approach and its relationship to the emotional well-being of the individual who is affected by environmental pollution or who is potentially affected by environmental pollution.
   4. A study of the relationship of values clarification to the conceptual approach in dealing with environmental pollution education.
5. A performance or teaching experience will be incorporated within the course of study.

E. A study of environmental pollution education and the identification and characteristics of children of different ages and grade levels receiving environmental and pollution education.

F. A study of the introduction and relationship of various types of learning theory as it applies to children of different age and grade levels, and as it pertains to environmental pollution education.

G. A study of evaluation techniques dealing with environmental pollution education.

**Consumer Health Education**

A. Introduction and status of the consumer health problem.

B. Basic facts and cognitions of consumer health education.
   1. A study of consumer buying and its effects on emotions and behavior.

C. A study of the relationship of consumer health problems and poor emotional and mental health.

D. A study of the introduction of various teaching methods and techniques for consumer health education.
   1. A study of conceptual teaching as it relates to consumer health education.
   2. A study in writing behavioral objectives or performance objectives that deal with consumer health problems.
   3. A study of the values clarification approach and its relationship to the emotional well-being of the individual who is affected by consumer health problems or who is potentially affected by consumer health problems.
   4. A study of the relationship of values clarification to the conceptual approach in dealing with consumer health problems.
5. A performance or teaching experience will be incorporated within the course of study.

E. A study of consumer health education and the identification and characteristics of children of different ages and grade levels receiving consumer health education.

F. A study of the introduction and relationship of various types of learning theory as it applies to children of different age and grade levels, and as it pertains to consumer health education.

G. A study of evaluation techniques dealing with consumer health education.
   1. A study of the function and criteria of measurement.
   2. A study of the measurement of health knowledge and attitudes as they pertain to consumer health education.

Organization and Administration of Health Education

A. Introduction and status of the organizations and administration of health education in the public schools.

B. Basic principles and facts dealing with organization and administration of health education in the public schools.
   1. A study of organization and administration principles of health education for public school educators and its effects on the emotions and behavior of pupils, faculty, and staff.
   2. A study of the various types of organization and administration leadership employed by public school officials dealing with health education in the public schools.

C. A study of the relationship of organization and administration to the emotional and mental health of pupils, faculty, and staff.
   1. A study of personality types and comprehension of the signs and symptoms of extreme anxiety, and frustration in oneself and others as related to personnel management within the public school system.
   2. A study of various means and methods of assigning and administering duties or tasks associated with health education programs in the public schools.
D. A study of school health law as it relates to administrators, faculty, students, and the school community.

E. A review study of the current health needs of the community and the conversion of those needs into a comprehensive school health curriculum.

F. A study of various means and methods of administrative evaluation of faculty, staff, and the health education curriculum.

G. A study of evaluation techniques dealing with alcohol and drug education.

1. A study of the function and criteria of measurement.

2. A study of the measurement of health knowledge and attitudes as they pertain to alcohol and drug education.
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